UNIVERSITY OF ALBERTA

Leadership Without Bosses:
Shared Leadership in a Multi-Organizational Context

BY

©

Christopher Stephen Elliott

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Department of Educational Administration

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled LEADERSHIP WITHOUT BOSSES: SHARED LEADERSHIP IN A MULTI-ORGANIZATIONAL CONTEXT submitted by Christopher Stephen Elliott in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Dedication

To Anne, Garth, Paul, and Karen

A team effort: Without your love this would have been impossible

Abstract

The research problem for the study was to investigate the exercise of leadership as a shared phenomenon. A case-study approach, involving prolonged and persistent observation over a period of four months, the holding of formal and informal interviews, and document analysis was used. The study was of the planning of a health network based upon two hospitals, a health unit, and a nursing home. The participants included administrators from each of the four health agencies.

Three leadership themes, vision, communication, and teaching, were found to have emerged. Sharing of leadership was found to have occurred within each of these themes.

The vision for the health network was based around the concepts of collaboration and equal partnership and the collaboration was based on the development of an atmosphere of honesty and trust. A major contributor to this was the effective management of symbols. The language used and behaviour exhibited were representative of the values that were held to be important. The calling of meetings, the setting of agendas, and the chairing of meetings were all rotated, and the preparation of the documentation was not the province of any one individual. These arrangements were all representative of the sharing of leadership and stood as symbols of that intent. These activities both facilitated and practised the sharing of leadership.

The participants exhibited a variety of understanding about leadership behaviour. These understandings appeared to relate to their individual realities and of their conceptions of the organizational cultures in which they found themselves. The assumptions held by the participants appeared to be the determinants of the meanings that they ascribed to leadership and their own role as leaders.

The linkage between the values, process, and leadership themes that emerged require that a leader ask questions of group members so that the various understandings can be clarified. The implication for administrators--including those in traditionally bureaucratic organizations-- is that if members of an organization are provided the opportunity to contribute to the definition of the values, processes, and direction-setting for their organization a positive, creative, and proactive organizational climate can be the result.

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To Ted Holdaway, thanks for on-going advice and assistance from the first day of my program right up to the word of encouragement immediately prior to my defence.

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CHAPTER ONE

Overview and Purpose of the Study

Introduction

The organizational world of today has been described as a "period of transformation" (Drucker, 1992) in which those in organizations need to reorganize to cater for the changes that are occurring. Peters (1987) writes,

> Most fundamentally, the times demand that flexibility and love of change replace our longstanding penchant for mass production and mass markets, based as it is upon a relatively predictable environment now vanishing. . . . The true objective is to take the chaos as given and learn to thrive on it. The winners of tomorrow will deal proactively with chaos, will look at the chaos per se as the source of market advantage, not as a problem to be got around. (pp. xi-xii)

The way in which we regard organizations is being refashioned and this is reflected in the language we use. Handy (1989b) writes, "Today's language is not that of engineering but of politics, of teams and coalitions, of influence and power rather than control, of leadership not management" (p. 89). Drucker (1992) describes the requirements of organizations and how they have changed over time:

> If the organization is to perform, it must be organized as a team. When modern organizations first arose in the closing years of the nineteenth century, the only model was the military. . . . The army was organized by command-and-control, and business enterprise as well as most other institutions copied that model. This is now rapidly changing. As more and more organizations become information-based, they are transforming themselves into soccer teams or tennis teams, that is, into responsibility-based organizations in which every member must act as a responsible decision maker. All members, in other words, have to see themselves as "executives." (p. 102)

This broadening of the responsibility-base has in many organizations resulted in a decentralization which accepts that decisions are best made close to the customer and the market-place. Handy (1992) describes the companies that are restructuring, integrating and creating "leaner, meaner" corporate centres as being "on a path to federalism as the way to govern their increasingly complex world" (p. 59). In discussing their research Larson & Lafasto (1989) refer directly to this complexity in stating,

> It is also clear that the problems facing our local communities, commercial organizations, and our national government will increasingly require the input and jointly coordinated action from several people--that is, a team. And, as the complexity of these problems increases, the consequences of ineffective teamwork is a fundamental step in assuring our future survival. (p. 7)

Handy (1989b) notes, "The world of work is changing because the organizations of work are changing their ways. . . . This applies to hospitals and schools and employment offices as much as it does to businesses of all sorts" (p. 87). The existence of these pressures creates the need for effective leadership. Peters (1987) refers to the way that current organizational trends affect leaders:

> The same principles for success prevail in the public sector as the private sector. . . . Even the language is the same among the best in the public sector--that is, the customer is identified and made central to all affairs in the top schools, cities, state agencies. . . . First-in-line employee involvement and improvement programs in pursuit of responsive service are the essential concern of top public sector bosses. (p. 38)

Fullan & Steigelbauer (1991) call on leaders to work with subordinates in the development of a shared purpose. They assert that a school principal's "larger goal is in transforming the culture of the school. . . . The principal as the collaborative leader . . . is the key to this future" (p. 161). As is noted by McPherson, Crowson, & Pitner (1986),

> Setting purposes and directions and goals is not simply the province of the bosses; it is a task that the people of the organization share whether the bosses like it or not. And the other two key executive functions--eliciting the cooperation of others and establishing communication networks--are shared activities, Barnard would argue. Shared leadership. (p. 356)

Barth (1990) asserts, "While much of the current literature suggests that effective principals are the heroes of the organization, I suspect that more often effective principals enable others to produce strong leadership. The best principals are not heroes; they are hero makers" and leadership needs to be considered "not only in terms of role, but in terms of function" (p 144). "It is less important who performs the functions than it is to what extent the functions are performed" (Murphy, 1988, p. 128).

Kouzes & Posner (1987) come to a similar conclusion, stating that "myth associates leadership with superior position. It assumes that when you are on top you are automatically a leader. But leadership is not a place, it is a process. It involves skills and abilities that are useful whether one is in the executive suite or the front line" (p. xviii). Larson & LaFasto (1989) describe effective leaders as those who "give team members the self-confidence to act, to take charge of their responsibilities, and make changes rather than merely perform assigned tasks. In short, leaders create leaders!" (p. 128).

Hunt (1984a) also underlines the importance of followers in the leadership process and the idea is pursued by Sergiovanni (1991) when he states, "What it means to be a follower and what it means to be a subordinate are very different. Subordinates respond to bureaucratic authority and sometimes to psychological authority. Followers, by contrast, respond to ideas" (pp. 327-8). The leadership process is "conceived as an interaction" (Bass, 1960) and is a social phenomenon (Chemers, 1984).

The relationship between leaders and followers is referred to by Foster (1989), who states that "leadership cannot occur without followers and many times the two are exchangeable: Leaders become followers and followers become leaders" (p. 42). Angus (1989) writes, "Leaders must engage followers such that there is mutual commitment to the shared purpose of building the best of organizations" (p. 70).

The facilitation of the sharing of these functions among the different individuals in an organization allows the emergence of multiple leaders and interdependence in groups. Such concepts reflect what is described by Joly, McIntyre, Staszenski, & Young (1992) as a feminist reconstruction of leadership, whose "elements are that power is shared, that morality is relational and situation specific, that community is essential, and that leading is done by different people in different contexts" (p. 2).

The issue is pursued by Angus (1989) who states,

> The important point here is not only contingent upon the particular context in which superior-subordinate relationships are continually being negotiated and re-negotiated, but also . . . [that] leaders and others operate within a broader social, cultural and political context which influences the nature of choices available to them. (pp. 78-9)

Organizational restructuring in response to political pressure for change has become evident in many countries and is evident in the health systems in Canada. In the United States of America the commitment of the newly elected President Clinton to establish a national health system promises significant structural change for the health system in that country.

In the United States numerous school-based employee participation programs have been reported. These have included programs in Denver, Seattle, and Fairfax County (*Employee Participation Programs,* 1988), programs in Virginia, New Jersey, and Oregon (*Ventures into Good Practice,* 1989), in Massachusetts, Texas, Ohio, Utah and Pennsylvania (Wynn & Guditus, 1984), and in California and Colorado (Timar & Kirp, 1988). In other Western countries, including France, Italy, Sweden and the Netherlands, where the administration of education has traditionally been the responsibility of a central office, decentralization, and the trend toward the phenomenon of self-managing schools has also occurred (Caldwell, 1988).

Changes in Educational and Health Administration

Essentially, changes in the public administration of education have been aimed at encouraging the self-management of schools, a trend which Beare (1983), Caldwell (1987), and Harold (1989) have suggested has been occurring in many western countries because of "the general perception that governments at all levels [have been] wasteful, inefficient and unresponsive to community needs, and that there [has been] a financial necessity to ensure the public received more 'value for money' from the tax dollar" (Harold, 1989, p. 2).

Similar types of developments have occurred with the decentralization of health administration in several Canadian provinces, where governments have announced plans to regionalize health administration. Part of the reasoning behind the restructuring of health administration can be traced back to the desire to reduce costs to government (Harold, 1989), but there is evidence that both politicians and health care leaders in general "want a New Civilization in healthcare with greater emphasis on prevention and healing, as well as universal, cost-efficient, community-based managed care" (Bridging the Gap in Healthcare, 1992, p. 3). As is noted by Armitage & Bain (1992), "The current trend [in the health services industry] is towards a decrease in the development of costly, technological service--such as those provided in hospitals--and an increase in home care and community-based programs" (p. 29).

The organizational restructuring that is occurring in a number of Canadian provinces, along with the change in emphasis for healthcare has placed new demands on health administrators. The changes have been described as a "paradigm shift" by Moeller & Johnson (1992) and they describe their expectations:

> In the next century we expect to see healthcare moving away from its present fragmentation towards a seamless continuum of services. . . . The culture, structure, and systems of tomorrow's healthcare organization demand a new type of leader--a transformational leader whose responsibilities are organizational in nature. Leaders will focus less on accomplishing tasks and more on developing people and managing processes. (p. 28)

The traditionally hierarchical organizational structures that have been found in educational and health-service organizations are likely to require a redefinition of the relationship between superiors and subordinates to one between colleagues, a relationship between leaders and group members.

The Study Focus

That all group members be considered when performing leadership actions is one of the common threads running through the literature on leadership. Barnard (1956) states, "Community puts the emphasis not on the group but upon the living in common and upon interdependence through communication. It expresses the generality of relationships among the people of a group which makes of it a society" (p. 144). Some of the most recent literature (Bacharach & Conley, 1989; Barth, 1990; Clark & Meloy, 1989; Sergiovanni, 1991; Steingold,1990) includes calls for the dispensing with hierarchical organizational structures and "top down" leadership styles.

The criticism of hierarchical structures for organizations has been a central plank in feminist critique with views such as those of Noddings (1990) who states, "Just as men have dominated, and still dominate, women, so the wealthy and better educated dominate the poor and less educated. Hierarchical structures serve as a continuance of domination, and thus hierarchy has become a target of feminist reform efforts" (p. 396). Feminist literature appears to have influenced the way in which thinking about leadership has developed. Blackmore (1989) writes,

> It is necessary, therefore, to reconstruct a view of leadership which counters the emphasis on individualism, hierarchical relationships, bureaucratic rationality and abstract moral principles. I propose, therefore, elements of what would constitute a feminist reconstruction of the concept of leadership. These would include a view of power which is multi-dimensional and multi-directional. Leadership is seen as being practised in different contexts by different people and not merely equated to formal roles. Leadership looks to empower others rather than have power over others. (p. 94)

The current study was conducted with the aim of expanding the understanding of leadership, particularly with regard to the manner in which it may be exercised as a shared phenomenon. Research into leadership at the University of Alberta has been limited, with few studies in the area having been completed (Miklos, 1990). There is evidence in the literature that suggests that leadership is a central issue in organizational effectiveness (Haughey & Rowley, 1991; Holdaway & Ratsoy, 1991). Traditionally, much of the literature has referred to "the leader" and has placed an implicit connection between leadership and position, but there appears a new wave of thinking.

This "new wave" is reflected in the concept of shared leadership referred to by Barth (1990), who comments that "shared school leadership is a timely, volatile, and I think very promising issue for the improvement of schools from within" (p. 145). Barth (1991) goes on to describe the sharing of leadership as an "Everybody wins logic. . . [with] positive outcomes for everyone--recognition, compensation, dignity, participation" (p. 125). Sergiovanni (1992) calls for the involvement of all members in an organization and writes, "When professional socialization, purposing and shared values, and collegiality are emphasized, they become substitutes for leadership. This means that direct leadership from administrators can be less intense--indeed much more informal" (p. 96).

I brought with me a long-term interest in leadership to the current study . This general interest became both academic and professional following the restructuring of the Western Australian Education Department in 1987 which saw the creation of a decentralized system from the previously highly-centralized bureaucracy. Powers were devolved from the Central Office to the school level. A major part of the reforms was the requirement of principals to employ participative-management techniques and to involve staff in the creation of school development plans and similar policy-making activities.

As a principal in the system I was greatly interested in the reforms and they became the focus of the study of two schools in the Master of Education thesis *Leadership and change in schools: The case of district high schools in Western Australia* (Elliott, 1990). That study, which comprised bounded case studies in the naturalistic paradigm, found that the leadership in the schools was a composite of leadership from a number of individuals. The phenomenon of leadership was further investigated in the current study, using a similar approach but moving away from a purely educational setting in the attempt to gain a richer understanding.

Barnard (1956) writes that leadership "depends on three things--(1) the individual, (2) the followers, and (3) the conditions" (p. 84) and these remarks remain as centre points to much more current statements on the subject. Research by Eblen (1987) into leadership in hospitals, and into the clerical, police, maintenance, parks and recreation, and engineering departments of city government administration indicates that the needs of the individuals are essentially intertwined with their situational context. As an outcome of that study Eblen comments, "Leadership/commitment relationships seemed to fluctuate from situation to situation. . . . The complexity of leadership style/social skills/commitment relationship establishes the need for exploration in this area" (pp. 192-3).

Sergiovanni (1992) sees leadership as being more than the "style/social skills/commitment" referred to here, however. He states,

> I believe that there are two reasons for the failure of leadership. First we have come to view leadership as behaviour rather than action. . . . We have separated the hand of leadership from its heart . . . [and] the process of leadership from its substance. (p. 3)

Further, the connection of social skill to commitment is criticized by Watkins (1989) as having overtones of manipulation. He states,

> If one looks at more basic underpinnings of social relations, the charge might be avoided that too often leadership concepts have become tainted by the manipulative overtones implicit in much of the research discussed in this chapter. In schools also the facile employment of a "motherhood" term like leadership can obscure the seduction and subversion carried out in the name of administration. In such a context leadership can be reduced to the exploitation of the school community through the manipulative and subversive tactics of those in powerful management positions. (p. 31)

Similar charges are directed by Angus (1989) at what he describes as the "new" literature on leadership which, "like most of its predecessors, still assumes the appropriateness of traditional bureaucratic power that are thought to be apolitical . . . [and] upon functionalist assumptions which largely ignore political and ideological differences of organization and bureaucracy" (p. 75). These issues were important in the curent study.

The current study was of a group of health administrators in a western Canadian province following the announcement by the Minister of Health that the provincial health system would be regionalized. Health administrators were expected to negotiate the creation of health regions which would accommodate their local needs. There arose the opportunity to conduct a study in a situation where there occurred the "paradigm shift" and "the requirement of leaders to focus on developing people and process" referred to by Moeller & Johnson (1992), above.

Health facilities in the province had, until the Minister of Health's announcement, been, governed, funded, and operated as separate entities. The "paradigm shift" required a change in thinking both with regard to the traditional mode of organization and in a shift from a treatment-and-curing function within the health system as a whole to one with greater emphasis on preventative medicine.

The necessity for administrators from different facilities to negotiate with one another about the use and sharing of resources demanded a level of inter-organizational cooperation not previously required. Political issues were of extreme importance because the reform of the health system implied a reduction and redistribution in funding and associated competition for scarce resources.

Because they were dealing with members of other organizations the participants in the study, many of whom were chief executives, could not rely on hierarchical position as the basis for their interaction with others. They needed to be able to disregard differences in status and power and to be able to negotiate with one another to satisfy mutual needs. Successful negotiation would require that they change from a bureaucratic way of thinking. Such thinking, according to Angus (1989),

> amounts to an ideology because the rhetoric and logic of bureaucracy structure the way participants talk and think about organization and appropriate ways of operating. Bureaucratic ideology provides strictures for interpreting what count as problems and for conceptualizing possible solutions to them. In these ways, bureaucratic structures and modes of thinking encourage compliance with established interests and the expectations of administrators. There is a tendency for individuals to define themselves in relation to the organization in such a way that subsumes the self into the larger bureaucratic structure. (p. 78)

There is evidence that bureaucratic structures need not always create the strictures referred to by Angus (1989), above. One example where this was not the case was found by Blackmore (1991) in a study of six women in senior administrative posititions in Australian state education systems.

One participant in Blackmore's (1991) study stated that "seniority and position does give you more leeway to act" and that a senior position could be of advantage in "helping to analyse what the situation is, so people understand what they are doing in one place and how it relates to or doesn't relate to what is going on elsewhere" (p. 26). Blackmore (1991) found that

> it is evident that leadership is closely associated with the notion of responsibity to and empowerment of others. This empowerment is effected by the sharing of ideas through democratic processes, in developing what one calls a politics of care and mutual support rather than of dependency or subordination. (p. 35)

There appeared in the current study a similar relationship. In relating to each other the participants in the current study did not have a relationship that was premised on a hierarchical position, referred to by Foster (1989) as the bureaucratic/managerial model where "leadership is a function of organizational position [and] the 'leader' is the person of superior rank in the organization" (p. 44). This could not be applied because the participants were from different organizations. Required was what is described by Foster (1986) as leadership that "is shared because no one individual has the right way: . . . [A] communal endeavour wherein the direction of the society is discussed and debated" (p. 19).

These issues were addressed in the research problem which was:

To investigate the exercise of leadership as a shared phenomenon in order to increase the understanding of the nature of leadership and the meanings attributed to leadership activity by the various participants.

The research problem was addressed by seeking answers to the following questions which provided the focus for the research;

In what ways is leadership a shared phenomenon?

What do leaders do to facilitate the sharing of leadership?

In what ways do the understandings of leadership activity vary from individual to individual, and what, if any, impact does the existence of a variety of understandings have on these individuals' behaviours?

The Selection of the Research Site

The process of selecting the research site occurred over a period of several months and involved consulting with a number of people involved in different fields. Experts in business, physical education, sociology, law, and hospital administration were consulted in the search for a site that would meet the research requirements. The objectives of the research were described to each of these experts and it was explained that a researchable site at which shared leadership was occurring was being sought.

After a number of meetings with different people, I was referred to an academic in hospital administration who said that he would be delighted to help in the selection of a site, adding that he would think about the hospitals that he knew that fitted the criteria for the study. Hospitals have traditionally been organized using a bureaucratic model in which a clearly defined hierarchy exists. Given the purpose and operation of hospitals, however, the appropriateness of this form of organizational structure has been questioned and the establishment of different structures and methods of operation has been attempted at various sites, with varying degrees of success. A hospital where such efforts were being made was found and when access to the site was successfully negotiated the hospital became the study site. This hospital was in the town of Timberwell in the environs of La Fontaine, the capital city of Western Province.

Between the time of gaining access to the site and beginning the research the Minister of Health announced the planned regionalization of health administration in the province and when the data collection began it became obvious that the prime concern of the administrative team at the hospital was the regionalization issue. As the study progressed it became clear that it should be relating to the creation of a health network involving that hospital and three other health agencies, Eaton Hospital, Timberwell Health Unit, and the Timberwell Nursing Home.

The Significance of the Study

Leadership is of interest in business, public administration, health, education, and politics. Political scientist Barbara Kellerman (1984a) states, "Knowing more about leadership will enable us to better understand our past and present and, hopefully, to better manage the future" (p. xi). In support, Bahr Bleedorn (1988) writes, "One of the most crucial problems of modern society has been the need for the development of talented leadership equal to the challenge of change and the complexities of the advancing global age" (pp. 5-6).

For the purposes of this study leadership is defined as relating to mission, direction and inspiration (Fullan & Stiegelbauer, 1991) and the showing of a direction in which to head (Kouzes & Posner, 1987) but, as is asserted by Foster (1986), leadership "resides in actions and acts, not persons and positions" (p. 18). Watkins (1989) sees the problem as being that "too often what is in reality a power relationship is obscured by the label of leadership. The result is that the literature on leadership adopts a fairly descriptive, simplistic and naive view of the concept" (p. 11).

The leadership that occured took place without being dependent of what Blackmore (1991) describes as the four assumptions of the conventional interpretation of educational leadership; "Formal authority is synonymous with leadership. . . . [T]his authority is necessarily imparted through hierarchical relationships. . . . [L]eadership is technique and expertise. . . and leadership means making rational decisions based upon empirical evidence" (p. 20).

The experience of working together in the process of the creation of a health network was new to all of the participants. The relationships between the study participants, for the most part, reduced the concern expressed by Smyth (1989) that "the notion of one group (the leaders) who exercise hegemony and domination over another (the followers) . . . [is], in a sense, an anti-educational one" (p. 179). The study thus has the potential to be meaningful for educational leaders in addition to leaders from the health and other sectors.

A comment from Smyth (1989) applies well to the relationships between the study participants and may best describe the potential significance of the study. He states,

> If leadership has little to do with hierarchical impositions, then it has a lot to do with enabling the "best" ideas to emerge wherever they come from, through a process of informed and rational debate. The kind of participative structures that are involved allow all "voices" to be adequately heard regardless of class, race, gender, or position in the formal hierarchy of the school. (p. 191)

The differing realities constructed by the individuals involved are likely to stand central to such an inquiry and the way those realities are constructed is likely to be an important aspect of the way an organization evolves. Bates (1989) takes account of the the importance of individuals' conceptions when he pursues the concept of envisioning organizations as invented social realities. He addresses the issues of agency and structure, where the individual and the organization are

> defined and re-defined in terms of each other; that is dialectically. . . . Such a position sustains Greenfield's attack on the reification of organizations implicit in administrative science, but extends his argument to show not only how the "invented social reality" of social practice is reconstituted by individuals but also how such social practice simultaneously plays a part in the constitution and re-constitution of individuals. (pp. 139-40)

Smyth (1992) refers to the importance of the attitudes of participants, in the context of establishing newly structured organizations, in stating,

> The problem . . . is that, while the rhetoric of participation provides the opportunity for significant change, as long as members of the school community continue to regard schools as being composed of established, neutrally defined role positions which remain much the same regardless of whoever occupies them, we should not be too surprized when real change is severely circumscribed. (p. 272)

Further, as Fullan & Stiegelbauer (1991) remind the reader, "There are no hard-and-fast rules, rather a set of suggestions or implications given the contingencies specific to local situations. . . . What works in one situation may or may not work in another" (p. 47).

Peters (1987) writes that the successful leaders of today are those that listen to others and must become "leader[s] as lover[s] of change and preacher[s] of vision and shared values, strategy development radically bottom-up, [where] all staff functions support the line rather than vice versa" (p. 43).

Delimitations, Assumptions, and Limitations

Delimitations

1. The study was delimited to the participating health agencies in an area comprising two towns.

2. The study was delimited to the focus on the activities of one health administrator and his colleagues involved in the planning of the health network.

3. The study was delimited to the period between mid-June and mid-November 1992, during which time the planning for the health network took place.

4. The study was delimited to the investigation of the leadership behaviour and did not include the study or analysis of other issues relating to the regionalization of health.

Assumptions

Assumed for the study is:

1. the suggestion by Fullen & Stiegelbauer (1991) that "change is a process of coming to grips with the multiple realities of people" (p. 95);

2. that leadership is not the province of a single individual;

3. that the case study method is appropriate for the study; and

4. that the participants presented honestly and accurately their perceptions and views of events and situations that comprised the case.

Limitations

1. The study was of one group of health administrators and the generalizability of the study is limited.

2. The study was limited by my ability to obtain relevant and appropriate data through observation, interview, and document analysis.

3. The study was limited by my ability to understand the meanings placed upon the situations and events of the case by the participants.

Definitions

Acute-care hospital: A hospital providing emergency, in-patient, and out-patient services where the level of care demands that the service be provided within the hospital.

Health programs: An amalgamation of inter-related services which promote health and well-being and which protect, maintain, or improve the health of targeted populations.

Health unit: An agency with the mission to promote optimal health in the community through the promotion of healthy lifestyle choices, the prevention of illness, and the protection of the community from illness.

Leadership: "Relates to mission, direction, inspiration" (Fullan & Stiegelbauer, 1991, pp.157-8) and is shown by "those who 'go first,' . . . who step out to show others the direction in which to head. They begin the quest for a new order" (Kouzes & Posner, 1987, p. 32). "Leadership must be critical, transformative, educative [and] ethical" (Foster, 1989, p. 51).

Management: "Involves designing and carrying out plans, getting things done, working effectively with people," (Fullan & Stiegelbauer, 1991, pp. 158).

Nursing home: A home providing for auxiliary and long-term care for those, usually aged people, that require institutional assistance in their living.

Regionalization: The creation of an integrated and collaborative health system through the formation of planning networks presenting a multi-sector approach to community health.

Shared leadership: When "no one individual has the right way: . . . A communal endeavour wherein the direction of the society is discussed and debated" (Foster, 1986, p. 18).

Outline of the Thesis

The dissertation comprises four parts. Part One comprises Chapters 1-3. Chapter 1 introduces and provides the background and purpose for the study. Chapter 2 presents a brief review of the literature on leadership and traces the development of thought to the commencement of the study. Chapter 3 describes the philosophical stance taken and details the methodology of the study.

Part Two of the dissertation comprises Chapter 4 and is the Case Study Chronology, the story of the events of the case. Part Three comprises Chapters 5-7. Chapter 5 suggests how the conceptualizations that the participants may have had of their own organizations may have affected their actions in the creation of the health network. Chapter 6 analyzes the concepts of organizational culture, and the symbols and politics in the network-planning process. Chapter 7 draws from the previous two chapters and analyzes the leadership behaviour that occurred in the study.

Chapter 8 comprises Part Four of the report and contains a consideration of the themes that emerged from the study and outlines the study findings. The chapter concludes with a discussion of implications of the study and proposes suggestions for further study.

CHAPTER TWO

A Review of the Literature on Leadership

Introduction

A number of threads running through the literature on leadership can be identified as emanating from some of the earlier writers, including Barnard (1956), who draws on papers he delivered as early as 1940; Maslow (1954); Bass (1960); and the more recent Burns (1978). In addition to these, the work of Argyris & Schön (1978) and Herzberg, Mausner, & Snyderman (1967) have also been important. Indeed, Burns (1984) makes the point that "much of the recent work on leadership . . . consists of clarification of earlier concepts and the discarding of inadequate ones" (p. vii). There have been developments and refinements on those earlier writings, particularly with the linking of leadership and culture. More recently, due at least in part to the influence of feminist critique, from writers such as Blackmore (1989; 1991), Cullen (1992), Noddings (1990), Lipman-Blumen (1983), Schmuck (1987), and Shakeshaft (1981; 1989), and from critical theorists such as Angus (1989), Foster (1986; 1989), Smyth (1986; 1989; 1992), and Watkins (1989), leadership is being considered as a shared phenomenon.

One of the continuing conundrums has been the uncertainty about what leadership is and how it can be defined. In a paper delivered in 1940 Barnard (1956) states,

> I shall not tell you what leadership is or even to determine when it is present; for I do not know how to do so. Indeed, I shall venture to assert that probably no one else knows. . . . At any rate, what I intend to discuss is *the problem of understanding the nature of leadership*. (p. 84)

The comment still holds. Wynn & Guditus (1984) attempt to sum up the position when they state that "leadership involves the initiation of new structures or procedures for accomplishing an organization's goals and objectives . . . [and] involves questioning and challenging . . . . The abundance of definitions indicates the complexity of the concept" (p. 28). In fact, Cunningham (1985) goes so far as saying,

> In many respects, leadership is whatever people believe it to be. . . . It is exercised somewhat differently in the private sector than the public sector, and still differently in the civic sector. . . . The contexts within which leadership occurs in each of these sectors are similarly diverse, calling on leaders to perform in ways that reflect each context. (p. 17)

In addressing the issue, Zaleznik (1989b) takes a distinctly management-oriented approach to leadership and presents the view that leaders are

> traditionalists in the art of using power [and] give short shrift to broad philosophical questions concerning human nature. Whether humanity is inherently good or bad, virtuous or sinful, has little bearing on the problem of getting other people to work cooperatively in organizations. (p. 244)

Such views are a long way from those of perhaps the most influential thinker and writer on leadership, James McGregor Burns. Burns (1978) describes what he says is the most potent form of leadership, transforming leadership, as "a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents. . . . Moral leadership emerges from, and always returns to, the fundamental wants and needs, aspirations and values of the followers" (p. 4).

Many writers reject the concept of leadership understood by writers such as Wynn & Guditus (1984) and Zaleznik (1989b) and move more toward Burns' conception of leadership. Smyth (1989) states,

> It is interesting to speculate on Pondy's (1978) question about what the field of leadership, as it relates to schools in particular, might look like if we move away from the view of leadership as involving manipulating (or influencing) others toward goal-setting and achievement. According to Pondy, leadership encompasses the process of making activity meaningful for others. Providing others with a sense of understanding where they have come from, what they are doing, and where they are headed, amounts to construing action so that people can extract meaning from it and communicate about those meanings. Generating knowledge in a social context, such as this, enables meanings to be viewed as social artifacts capable of being exchanged, talked about, modified and amplified. (p. 181)

Leadership is of interest in business, public administration, education, and politics. Each of these contexts will be considered in this chapter and the literature on leadership from ideas presented prior to World War Two through to the present will be examined.

The Nature of Leadership

Over time the study of leadership has seen a number of schools of thought develop. Earlier this century there occurred the trait theories, when it was proposed that leadership would be found if people exhibited certain traits. Difficulties arose when different studies proposed different traits and, even if agreement of the most important traits was reached, an individual exhibiting them would not necessary become a leader. Further, there occurred leaders who did not exhibit traits that were defined as requirements for leadership.

Addressing this issue, Badarocco & Ellsworth (1989) write with regard to "charisma," one commonly proposed leadership trait,

> Many people believe that leadership is essentially a matter of charisma--a rare, elusive, transforming characteristic that sets leaders apart and compels others to follow them. This view is not false, but it is sorely inadequate and misleading. . . . By itself, charisma is neither necessary nor sufficient for business leadership. (p. 4)

While the statement made above is qualified as being business leadership and other contexts may apply it does not do much to assist in solving the problem of what allows a leader to become a leader. This was referred to by Fiedler (1979) when, following a series of studies on leadership, he commented,

> Such notable leaders as Joan of Arc, Alexander the Great, William Pitt, Charles Percy, and Robert Maynard Hutchins were highly effective, even though they were young and inexperienced. . . . The crucial variable . . . appears to be the stress in interpersonal relationships between the leaders and others, particularly the stress with the leader's immediate superior. (pp. 11-12)

Bass (1960) feels that the leadership process is "conceived as an interaction" and Chemers (1984) agrees, writing that leadership is much more than the traits of a particular individual--leadership is a social phenomenon. Watkins (1989) describes the critiques of trait approach to leadership as "devastating" but that because "the trait approach was obviously simplistic and could not withstand close scrutiny, the more complex situational approach was developed as part of the human relations strategy of management" (pp. 10-11).

The situational approach referred to by Watkins (1989) focused, in part, on the investigation into leadership styles, followed in the attempt to discover patterns of leadership behaviour. Of particular significance in this area were the Ohio State Studies (Hall & Hord, 1986; Hughes & Ubben, 1989). These studies suggested that there were two dimensions of leadership; initiating structure and consideration. The skills, abilities, behaviours, desires, attitudes, and perceptions of subordinates in a leadership situation were identified as being important consideration in determining leadership style.

From the Hawthorne experiments in the 1920's there had arisen interest in the thoughts and actions of subordinates (*Employee Participation Programs*, 1988, p. 9). The consideration of employees in the performance of leadership acts and the proposing of two dimensions of leadership--the task and the followers--was a common finding of the Ohio State Studies, the Michigan studies, and the work of Blake and Mouton. These studies were separate, but came to closely-related conclusions (Hughes & Ubben, 1989, p. 8). Blake and Mouton produced the Managerial Grid, which not only illustrated two dimensions of leadership, as the Ohio State studies had done, but that differing situations required differing leadership styles (Hall & Hord, 1987; Hughes & Ubben, 1989; McPherson et al. 1986; Wynn & Guditus, 1984).

The ease and manner in which group commitment is achieved, according to the contingency theorists, varies with the circumstances or, as Barnard (1956) termed them, the conditions. The varying situations in which leaders operate were considered by Fiedler (1977) to be important considerations in determining the most appropriate and effective leadership style. Fiedler's Contingency Theory of Leadership took into account the degree to which a situation was favourable for the leader. In a similar way to Fiedler, Hersey & Blanchard (1982) considered that differing conditions determined the most appropriate leadership style. In their theory of Situational Leadership the contingency was the maturity level of the subordinates.

The necessity for collaboration and the consideration of individuals' interests and expertise was central to the development of the Vroom-Yetton decision tree. Through the use of strategic questions, the stakeholders' concerns are accounted for and the appropriate degree of consultation of the group or of group decision-making is determined (Hughes & Ubben, 1986; Johns, 1988; McPherson et al. 1986).

These approaches, too, have been criticized. Bolman & Deal (1991) are critical of the approach of the contingency theorists because they fail to "distinguish between support for a person and support for a specific action" (p. 419). The situational approach "makes no distinction among different organizational levels, different industries, different sectors, or different cultures (p. 420), and neglects "many of the most critical challenges that leaders face" (p. 421).

Hayes (1983) is similarly critical of techniques of leadership being "too often inappropriately generalized . . . often by well-meaning people. But the result is no less unfortunate" (p. 4). Watkins (1989) is rather more caustic in his criticism of the situational approach, and comments,

> While the situational approach to leadership has been seen to be virtually worthless in its own terms, of controlling and extracting more work from subordinates, it has also been criticized for working by stealth in seeking to manipulate the employees of organizations. . . . Thus the main thrust of the research was concerned with extracting greater productivity while legitimizing the power status quo and the class relations of organizations. (p. 15)

In a summary of the literature prepared for graduate students at the University of Alberta, Barron, Creed, Gabregiorgis, Gilbert & Millikan (1978) referred to leadership as "the art of influencing others" (p. 2), but that leadership does not mean the same as a position in a hierarchy, a view shared by Hunt (1984a), who underlined the importance of followers in the leadership process.

Bennis (1990) emphasizes the interaction between the leader and the followers or, as Kosowski, Grabbe, Grams, Lobb, Willoughby, & Sines (1990) would describe them, the group members. Bennis (1990), indicating some commonality with the thinking of Watkins (1989), urges the empowerment of group members. Bennis (1990) comments,

> Leadership can be felt throughout an organization. It gives pace and energy to the work and empowers the work force. Empowerment is the collective effect of leadership. . . . People feel that what they do has meaning and significance. . . . Where there is leadership there is a team, a family, a unity. Even people who do not especially like each other feel the sense of community. (pp. 22-23)

The pursuit of broad objectives was presented as a key to leadership by Sergiovanni (1991), emphasizing the development of commitment in group members which strikes at the heart of the meaning of leadership. The existence of leaders at different levels in an organization leads to the idea of multiple leaders and interdependence in groups. The context in which the group exists is of great importance, however.

Context, Interdependence, and Leadership

That all group members be considered when performing leadership actions is one of the common threads running through the literature. Barnard (1956) states, "Community puts the emphasis not on the group but upon the living in common and upon interdependence through communication. It expresses the generality of relationships among the people of a group which makes of it a society" (p. 144). Some of the most recent literature (Angus, 1989, Bacharach & Conley, 1989; Barth, 1993; Clark & Meloy, 1989; Sergiovanni, 1991 and 1992; Smyth 1992; Steingold,1990) includes calls for the dispensing with hierarchical organizational structures and "top down" leadership styles.

These concepts are applied by Clark & Meloy (1989) when they make recommendations for the achievement of excellence in performance in schools. These authors asserted that a new school "must be built on the consent of the governed, . . . shared authority and responsibility, not delegation of authority and responsibility . . . and the goals of the new school must be formulated and agreed to through group consensus" (pp. 291-2). Bacharach & Conley (1989), who are specifically addressing educational contexts, report that research over the last few years concurs with the views of Clark & Meloy (1989). For a rounded consideration of leadership, however, a variety of contexts must be considered.

The importance of context as a determinant of leadership has been another thread running through the literature. In what he terms a "critique of a tradition" Greenfield (1968) criticizes those who considered leadership as though it occurred exclusive of the context. He states,

> An appropriate framework for the study of leadership must take seriously the organizational context. While making a minimum number of assumptions, adequate theories of leadership should take into account the sources of control in organizations, and the dynamics of both internal and external forces which influence the operations of the system. (p. 57).

Cronin (1989b) agrees that "leadership is tightly situational and contextual. . . . A leader has to resonate with followers. . . . Can an effective leader in one situation transfer this capacity this skill--to another setting? The record is mixed indeed" (pp. 47-8).

The degree of influence that context has on the behaviour of individuals may go at least part of the way in explaining the difficulties that have been experienced in understanding and defining social phenomenon such as leadership. An example of articles on similar research, by Wynne (1989) on the one hand and Clark & Meloy (1989) on the other, that produced totally contradictory findings may be explained in this way.

In a study of schools in the Chicago over a 15-year period, along with the study of the literature on both effective schools and their management and for a book on traditional Catholic religious orders, Wynne (1989) found that

> effective school management is fostered by the application of relatively traditional moral values . . . rooted in the Judeo-Christian ethic . . . [including] the acceptance of traditional hierarchy. . . . Communication and engagement should not be equated or confused with "democracy." . . . In schools, the adults are voluntary citizens. Essentially, they express their freedom by choosing to join the school and being free to leave. (pp. 127-133)

These findings could scarcely be further from the comments from Clark & Meloy (1989) who, in a background paper for a conference on the restructuring of education in the United States, rejected traditional assumptions about schools, including bureaucratic structures, appointed principals, and the school system setting the goals and the direction at system level. Clark & Meloy (1989) state,

> When administrators foster that compulsion [to succeed, to become what every person desires to become--an effective, recognized, rewarded individual in the work setting] in others, then the strength of the school as an adaptive, excellent unit increases permanently. When they fail to do so, the pills and the pats are useless tools for improvement. (p. 274)

The clue to the enormous difference between these two statements may lie in Wynne's (1989) references to "Judeo-Christian ethic" and "children of God." He refers to "many parallels between Jewish and Catholic traditions . . . [and that his] historical-religious research has developed new insights into the running of secular schools today" (p. 128). Wynne's findings may well reflect his own personal bias in addition to which his data may have been gathered from conservative, religious-based communities where the individuals' needs matched a style of leadership and organization that would be totally inappropriate for a different context and group of individuals.

The contrast in the ideas presented by Wynne (1989) and Clark & Meloy (1989) may well reflect the comment from Schein (1985) that "culture and leadership are really two sides of the one coin. One cannot be understood without the other" (p. 4).

This complex relationship was referred to by Barth (1990) in his comment that "successful principals, like successful college presidents these days, are successful less as charismatic authority figures than as coalition builders" (p. 133). There is a clear connection between these views and those of Kellerman (1984b) who writes, "Our political leaders would overcome America's persistent tendencies toward fragmentation and stalemate by skilled leadership which would concentrate on the pursuit of broad, public objectives" (p. 68). The world of politics is one in which a common assumption is that upon being elected to political office an individual automatically, and almost by right, becomes a leader. Leadership and position are not, however, synonymous, even in politics.

On Leadership and Position

When leadership is considered from a political perspective, context becomes most important. Proving to be somewhat predictive of future events, Mazlish (1984), in the paper in which he presented a discussion of leadership from a historical perspective, wrote of the importance of leadership with the comment,

> Any historical treatment of leadership must take into account the particular historical context. Leadership in Tsarist Russia cum Soviet Union is obviously different from leadership in a representative democracy, such as America. Periods of charismatic leadership are different from periods of bureaucratic leadership. (p. 3)

The occurrence of the charismatic leadership of Michail Gorbachev certainly produced times that were different from the more traditional Soviet bureaucratic approach. But charisma is itself contextual. Tucker (1981) observes that the highly effective leadership of the Winston Churchill of 1942 was no longer considered effective when he lost the general election of 1946. The contexts of the different situations required different leadership. The need for leadership to match the situation is illustrated in the way that Tucker (1981) describes leadership as a three-step activity; diagnosis, policy formulation, and policy implementation (pp. 18-19).

Tucker (1981) makes the point that "political scientists still prefer the seemingly more manageable project of analyzing politics--and leadership--in power terms" (p. 11), and goes on to say that in order to obtain people's active support, politicians must ensure that their constituents are "really persuaded of the correctness of a policy" (p. 62). Many current writers would question whether the "persuasion" referred to by Tucker (1981) is really "manipulation."

Although he did not use those terms, Bass' (1960) addressed the question of political "leadership" with the aim of manipulating public opinion as opposed to leadership in the pursuit of commonly developed objectives. He developed the idea of self-oriented leadership and task-oriented leadership and illustrated the ideas using examples from politics. If political leaders are self-oriented and seek power and prestige for its own sake or for personal gain, they will be successful only so long as they present policies that are agreed to by the required number of voters. A self-oriented leader appears to be motivated only by the desire to hold power.

The essential difference between these self-oriented and task-oriented leaders seems to hinge on the leader's motivation. Bass (1960) feels that since the self-oriented leader is concerned with "gaining esteem and status, he [or she] will cease attempting leadership if his [or her] attempts to influence are rejected" (p. 154). The task-oriented leader accepts a leadership position in order to accomplish a particular task. The concept of "vision," which will be explored below, is suggested by the idea of task-orientation. To develop policies in pursuit of a particular objective without consultation with the voters is risky, however, because an incorrect diagnosis of public opinion is likely to result in political annihilation.

One answer to this problem for politicians and political parties is the constant polling of voter opinion but there is no interaction between politician and voter in such a case. When the goal is the retention of power by tailoring policies to match public opinion the process is reaction, not influence. Following a study based on 550 surveys of 38 open-ended questions on participants' "personal best" and followed by 42 in-depth interviews, Kouzes & Posner (1987) define leaders as those who "'go first,' . . . who step out to show others the direction in which to head . . . [and] begin the quest for a new order" (p. 32). If this definition is used then "government by opinion poll" as described above is not leadership at all.

The existence of politics without leadership has commonality with Bass' (1960) thinking that "in most American communities, the attractions are not strong enough to stimulate task-oriented members to seek political office." He quotes Maslow's (1942) solution; "to maintain more effective leadership is for communities to seek out and draft task-oriented leaders" (p. 155).

Of course, there is no point in an individual seeking political office if what is sought is at variance with the wishes of a sufficiently large number of voters to prevent election victory. Chemers (1984), in stressing the concept of leadership as a social phenomenon, writes that "the leader and the group must engage in the functions of *information processing* and *decision making*. Goals are defined, problems solved, and procedures for attaining objectives are developed" (p.93, emphasis in original) in the context of "the social, economic, and cultural characteristics of the society" (p. 91).

The impossibility of separating the leader and the led, if anything constructive is to occur, was underlined by Mazlish (1984) in his discussion paper, when he commented,

> The leader does not exist, fully formed, before the encounter with the group he [or she] is to lead; he [or she] finds his [or her] style in the course of interacting with the led, . . . the leader leads in part by tapping into a "psychic repository"--myths, symbols, fantasies, and so forth--or culture prevailing among the led." (p. 13)

One of the most common ways of "tapping into the psychic repository" referred to above is through the manipulation of symbols. As described by Enns (1981), "symbol systems become very powerful, and such symbolic entities as nation, society, party, or organization may govern human behaviour even more fully than biological realities" (p. 6). Symbols can be used to misrepresent or distort reality, as was done by Hitler in blaming a communist activist for the burning of the Reichstag and representing the act as being symbolic of the Jewish-communist conspiracy, or by Stalin using the murder of Leningrad party leader Sergei Kirov for his own power purposes (Tucker, 1981, p. 62).

These two examples provide clear evidence of the way in which political "leadership" can be highly manipulative. The election of task-oriented leaders need not necessarily benefit the community as a whole. What must be remembered, as Bass (1960) noted, is that the task-oriented member must be attracted to the group's goals and will only continue leadership if this does not result in decreased group effectiveness (p. 155). In such circumstances the conclusion of political office would be expected to occur through resignation, electoral defeat, coup, or by some other method. Required is more than a self-oriented leader presenting a simplistic definition of a task at hand. A broad mission, sense of purpose, or vision that addresses the wants and needs of the population the holder of political office endeavours to represent is required.

Burns (1978) addresses these concepts in his landmark work. This work is landmark because Burns stressed importance of the followers and the mutuality of relationship between individuals.

The apparent lack of mutuality between the public and their political leadership is signalled by the degree of apathy and distrust that much of the population of different countries around the world seem to have with regard to politics and politicians. Zaleznik (1989b) notes, "The idea that a leader must be adored has now become so popular that it is almost a requirement that politicians take lessons in how to be charismatic before they seek public office" (p. 233). The learning of desirable ways of acting that such lessons provide is referred to by Sergiovanni (1992), when he comments, "There are two reasons for the failure of leadership. First we have come to view leadership as behaviour rather than action. . . . We have separated the hand of leadership from its heart . . . [and] the process of leadership from its substance" (p. 3). The apathy toward politics and lack of trust in politicians that is apparent in many countries of the world is perhaps because there is the perception that our politicians are rarely the leaders of substance that people really want and need. The voters' suspicion seems to be that in the name of leadership the politicians are in fact seeking to manipulate the electorate in pursuit of the politicians' own or their backers' self-interests.

Bates (1989) describes this manipulation as violence, although the violence is not necessarily physical, and states,

> Indeed, Weber saw politics as a matter, largely, of symbolic violence, of charisma where the force of will (echoes of Greenfield) on the part of "great men" provides justification for particular purposes and forms of social organization. The result is, however, the same. From the emotivist position there can be no justification for the moral choices of great men other than their success in imposing those choices on others. (pp. 148-9)

Mazlish (1984) comments, "Thus, while the 'great man in history' often took on mythical proportions, they could also turn into villains, as in Lord Acton's work" (p. 2).

The Edmonton Journal, of February 13, 1992 addressed the issue of politicians of the type referred to by Mazlish--those with the charismatic image often so sought by those in politics--with the comments relating to the 1992 primary elections for the United States' Presidency:

> The truth is that voters and reporters have conflicting feelings about the charisma factor. On one hand, voters say they're looking for answers to the problems they face--the recession, worries about health care and the rest. At the same time, there's a yearning among some for a knight on a white horse, a charismatic figure who can inspire the country, as well as manage it. Reporters, meanwhile, don't like slick or manipulative candidates, but they are quick to deride those with fuzzy messages.

The problem is that in an increasingly complex world it may not be possible to identify a common culture on which a leader may draw. Bennis (1990) asserts that the first thing a new CEO must do is to understand the organization's culture and to develop a vision for it. In recalling Franklin Rooseveld, Winston Churchill, Albert Schweitzer, Albert Einstein, Mahatma Gandhi, David Ben Gurion, Bobby and Jack Kennedy, and Martin Luther King, Bennis (1990) laments, "Where, for God's sake, have all the leaders gone?" (p. 59).

The answer to this question is that leadership requires more than mere election to political office or of holding some other chief executive position. Foster (1989) makes the point that "leadership . . . is not a function of position but rather represents a conjunction of ideas where leadership is shared and transferred between leaders and followers, each only a temporary designation" (p. 46).

The great leaders mentioned above were able to identify groups' goals and distill the essence of the goals into a vision, and Foster (1989) argues, leadership must be "critical, transformative, educative, [and] ethical" (p. 51). Bennis (1990) says of one of the great leaders of modern history;

> The leader knows what we want and what we need before we do and expresses those unspoken dreams for us in everything he of she says or does. When Martin Luther King spoke of his dream, for a moment, all of us, black and white, were one. . . . Deep in all of us there is still and always a need to believe, and one day a leader will appear who will express that need, and fulfil it. (p. 159)

Foster (1989) makes a similar connection between King and those in his political constituency but extends that linkage. Foster (1989) asserts that what took place with leaders such as Mahatma Ghandi and Martin Luther King was a

> transformation of *consciousness* is what took place, and as a result of that, a transformation of social conditions. But this required a community of believers, not just a "leader." Certainly one person can serve as a catalyst, but . . . such transformations occurred because of a community of leaders. (p. 52)

Fullan & Steigelbauer (1991) call on leaders, in a manner reminiscent of Martin Luther King, to work with subordinates in the development of a shared purpose but in doing so they form a tight connection between leadership and position. They create a firm connection between leadership and culture in stating that a school principal's "larger goal is in transforming the culture of the school. . . . The principal as the collaborative leader . . . is the key to this future" (p. 161). In presenting this view, Fullan & Stiegelbauer (1991) take what Watkins (1989) describes as the traditional stance of leadership, where there is a "one-directional flow from the leader to the led, from the principal to the school community, without realizing the reality in which a junior member of staff may be the leader and the principal the follower" (p. 10).

In addition, Fullan & Stiegelbauer (1991) leave themselves open to criticism from feminist writers such as Blackmore (1989) who writes,

> The hierarchical arrangements in organizations such as schools are thus premised upon such notions of individualism and rationality. . . . [T]he traditional notion of administrative leadership reifies the role of principal as leader. Principals are seen as being effective only when they are "in charge" or "in control." This encourages manipulation and control of subordinates by principals, generally not conducive to mutual benefit . (pp. 118-9)

If it is accepted that leadership and position are not synonymous, but that leadership is not the same as position but is an interaction between group members and is shared and transferred between them, then the concept of group culture must be to the forefront when considering the phenomenon of leadership.

Culture and Vision: The Centre-Pieces for Leadership

Of significance in considering great leaders such as Joan of Arc, Alexander the Great and the others mentioned above, the vision that they used to unite their followers arose *from* the followers. This is alluded to by Adair (1980) with the comment,

> There are three areas of need present in groups. Two of these are the properties of the group as a whole, namely *the need to accomplish the common task* and *the need to be maintained as a cohesive social unity*. . . . The third area is constituted by the sum of the *individual needs of group members*. With regard to the third area, it may be noted in parenthesis, that experienced leaders in all periods of history have realized that man lives by more than bread alone. (p. 9, emphasis in original)

The expression of a vision or direction that has its genesis in the needs of the followers is at the heart of what Burns (1978) was addressing when he differentiated between transformational and transactional leadership. Sergiovanni (1991) describes this difference in the following way; "Transactional leadership focuses on basic and largely extrinsic motives and needs; transformative leadership focuses on higher-order, more intrinsic, and ultimately moral motives and needs" (p. 125).

Although conducted long before Sergiovanni's (1991) writing, there appears similarity with the ideas mentioned above in the work of Herzberg et al. (1967). Following a study conducted into "nine industrial concerns [which] vary widely in both size and nature of their activities" (p. 30) and interviews with 203 subjects, they proposed the concepts of job satisfiers and dissatisfiers. The dissatisfiers were such things as salary, job security, physical working conditions and the types of factors that would likely by addressed by transactional leadership practices. Herzberg et al. (1967) found, "Improvement in these factors of hygiene will serve to remove the impediments to positive job attitudes" (p. 113), but that "the factors that lead to positive job attitudes do so because they satisfy the individual's [higher-order] need for self-actualization, or self-realization in his work" (p. 114), referred to above.

The sexist language and the identification of "self-actualization" as a need for all organizations' members are two of the aspects of this work with which feminists take exception. Despite this criticism, which will be considered below, the findings from the research by Herzberg et al. (1967) provides a contribution for subsequent work. There is the suggestion from this work, agreed to by Sergiovanni (1991), that effective leadership involves both the transactional and the transformative leadership described by Burns (1978).

A four-year study involving case studies and a review of the literature by Argyris & Schön (1978) produced findings that relate to leadership in a similar way. They refer to the problems that occur in hierarchical organizations when, "People . . . [have been] educated to develop many and complex abilities. Yet, the lower they go down the organization, the less it is likely that they can use those abilities" (p. 122). The strategy most commonly used to address this problem, according to Argyris & Schön (1978), is to express transactional leadership and focus on the kinds of issues that Herzberg et al. (1967) referred to as dissatisfiers. Argyris & Schön (1978) found that resulting from such an approach is that "group processes tend to become highly competitive, rarely additive, low in openness, trust, and risk-taking, high in closeness, mistrust, and emphasis on not rocking the boat. . . . Organizations are therefore full of intergroup warfare and rivalries" (p. 123) unless "double-loop learning occurs when error is detected and corrected in ways that involve the modification of the organization's underlying norms, policies, and objectives" (p. 3).

The connection of Argyris' & Schön's (1978) work with the concept of leadership, as it has been discussed above, would rest on the degree to which the modification of organizational "norms, policies, and objectives" through the process of double-loop learning occurred through an interaction between leaders and followers or whether the modifications were imposed upon members of the organization through bureaucratic power. Foster (1989) addresses this point in stating,

> Leadership will involve power relationships, and these in turn can be used in a positive or negative fashion. A negative power relationship involves the use of power to achieve those ends desired by the "leader," what Burns would label "power wielding." This means that the individual entrusted with some position of power uses that position to achieve objectives that are not of communal benefit, but of benefit to the aspirations of only that individual. Burns would not, and we agree, consider this leadership at all. (p. 55)

Similar to Argyris' & Schön's (1978) work in that it relates to harmony in the work-place is a much more recent study by Imberman (1989) into 62 unionized hospitals, 31 with low-strike history and 31 hospitals with a high-strike history. Imberman (1989) found that accounting for employees higher-order needs including "the degree of employee participation/involvement (upwards communication) . . . [and] overall employee perceptions of the hospital administration (downward communication)" (p. 199) resulted in fewer strikes by hospital staffs. Kotter (1985) proposed "aligning" employees with the organization's mission, describing aligning as

> more of a communications challenge than a design problem. . . . Alignment helps overcome [people feeling powerless] by empowering people. . . . Lower level [sic] employees can initiate actions without the same degree of vulnerability . . . [and] because everyone is aiming at the same target, the probability is less that one person's initiative will be stalled when it comes into conflict with someone else's. (p. 107)

Hayes (1983) relates such concepts to a historical context stating,

> By recognizing that spirited people make a difference, we have not really advanced the management art. . . . Long ago . . . it was found that, while mercenaries would fight for money and plunder, and slaves would fight well from fear and for freedom, free men would fight hardest and longest, and against any odds, to save their freedom and to accomplish the goals to which they had freely committed themselves. The lesson is still relevant today. (p. 11)

The perspective described above hinges on the words "freely committed," which is not to say that those fighting "longest and hardest" for their particular cause would have any control over the way in which the fight was conducted. In the same way, there appears no suggestion from either the Herzberg et al. (1967) study or the Argyris & Schön (1978) work that the workers in an organization would have control over the organization in which they worked. This is commented upon by Angus (1989) when he writes,

> The human relations [sic] approach, informed by organizational psychology and sociology, asserted that happy employees would be more productive employees, and that it was the job of management to stimulate and motivate their workers through appropriate expectations of them (McGregor, 1966), attention to motivation factors such as responsibility and recognition (Herzberg, 1972), and involvement of employees in forms of participatory management (Likert, 1976). While critics argue that this approach did little to give employees any measure of control over workplaces (e. g. Braverman, 1974), it nonetheless led to the reduction in many organizations of impersonal, mechanical forms of management. (p. 69)

An extension of this human-relations approach was reflected in a study of ninety successful leaders from corporations and the public sector (Bennis,1990) which found that there were "four leadership competencies evident to some extent in every member of the group: the management of attention; the management of meaning; the management of trust; and the management of self" (p. 19). In developing this point Bennis continues,

> So the first leadership competency is management of attention through a set of intentions or a vision . . . in the sense of outcome, goal, or direction. . . . The second leadership competency is management of meaning. To make dreams apparent to others and to align people with them, leaders must communicate their vision. . . . The leader's goal is not mere explanation or clarification but the creation of meaning. (p. 20-21)

The importance of vision is alluded to by Badarocco & Ellsworth (1989) when they state, "First and foremost, a company's strategy must be defined in terms that include and *transcend* economics. A company's goals must be both quantitative and qualitative" (p. 74). Following the study of eight effective principals, Blumberg & Greenfield (1986) wrote, "The elements of vision, initiative, and resourcefulness . . . characterize the general dispositions of the eight principals" (p. 181). The development of commitment in group members strikes at the heart of the meaning of leadership.

Similar to the above, Sergiovanni (1991) feels that to be the principal of an excellent school it is essential that principals make clear the direction the school is to go by displaying symbolic and cultural leadership. He includes management as the first, and most basic of his five leadership forces. The symbolic leadership force is expressed when a leader "assumes the role of 'chief,' emphasizing selective attention or the modeling of important goals and behaviours, and signaling to others what is important and valuable in the school" (p. 103). When expressing the cultural leadership force the principal is building the "culture that promotes and sustains a given school's conception of success . . . [and seeks] to define, strengthen, and articulate those enduring values, beliefs, and articulating school purposes and mission" (p. 104-5).

Angus (1989) is critical of this approach, writing,

> By asserting and defending particular values, it is argued, leaders so strongly articulate and endorse their vision that it becomes also the vision of the followers, and so bonds leaders and followers together in a shared covenant . . . which incorporates what then becomes the non-negotiable core values and beliefs of the organization. . . . [This presents the] notion of an organizational culture that can be in a sense manufactured and manipulated. (p. 70)

This author goes on to argue that such an approach is elitist in that it implies that "not only are leaders more visionary than anyone else but also, given the new emphasis on moral leadership, more trustworthy as well" (p. 73).

Again, it is important that the "leadership" referred to by Sergiovanni (1991), above, is not imposed but involves interaction, sharing, and mutual benefit. The study of a district high school in Western Australia by Elliott (1990) found that all members of the teaching staff were provided the opportunity to be leaders and that different people expressed the various leadership forces described by Sergiovanni (1991) at different times during the study. Their actions were interactive and in their mutual interest and were thus "leadership" in the sense it is used here.

Effective management establishes the conditions for competence but excellence requires what Sergiovanni (1991) describes as the application of the symbolic leadership force and the cultural leadership force by the expression, as action or words, of the key strands to the school culture.

The Leadership/Management Issue

Over time there has been a development in thinking about leadership and management. Mintzberg (1973) considers managerial behaviour to comprise 10 roles, one of which is leadership, and Yukl (1981) who writes that "since the definition of leadership and management are so ambiguous and closely intertwined, much of this book [entitled "Leadership in Organizations"] could be said to deal with managerial effectiveness" (p. xi).

A similar view emerges from Burack's (1979) research which involved contributions from four leaders from industry who had "achieved distinction in applied areas of leadership, management development, or various areas contributing to managerial effectiveness" (p. 26) writes that leadership was one factor that contributed to successful management, that managers could be successful because they compensated for weaknesses in one area with strengths in another. The importance of managerial skills was shown when it was found in assessing over 200,000 men and women in both research and applied environments assessed in American Telephone and Telegraph that only "25 percent of all participants demonstrated significant [leadership] skills (defined as leadership ratings of four or five on a five-point scale)" (p. 31). Badarocco & Ellsworth (1989) assert that outstanding managers are outstanding leaders and used the term "values-driven" leadership.

The differentiation between leadership and management was, for Badarocco & Ellsworth (1989), one of effectiveness. They describe leadership as what "answers the question of what distinguishes the man or women who create extraordinary organizations from workaday professional managers" (p.3).

Duke (1989) addresses the leadership/management issue by warning of simplistic thinking with the comments, "Role-based conceptions of leadership are too restrictive. . . . Making sense of leadership entails understanding what it means when people apply the term. . . . Leadership is first and foremost, a perception invested with social meaning and value" (347-8). The concept of vision, of values and direction, and the involvement of the organization community in seeking to attain them were evident in each of the three effective schools studied by Sharpe (1989), and, writes Sharpe, the principal as leader is essential to the process.

Bennis (1990) addresses those meanings and values in describing what he sees as the differences between leaders, identified by those who hold the position of Chief Executive Officer (CEO), and managers, identified as those who hold the position of Chief Operating Officer (COO). Although Bennis (1990) defines a leader as one who holds a given position contrary to the position accepted in this paper, his comment does illustrate how he differentiates between leadership and management. He writes:

> On paper the differences between the two jobs are very clear. The CEO is the leader, the COO the manager. The CEO is charged with doing the right thing, the COO with doing things right. The CEO takes the long view, the COO the short view. The CEO concentrates on the what and why, while the COO focuses on how. The CEO has the vision, the COO the hands-on control. The CEO thinks in terms of innovation, development, the future, while the COO is busy with administration, maintenance, the present. The CEO sets the tone and direction, both inside and outside the company, while the COO sets the pace. (pp. 78-79)

The importance of values and beliefs as guides for effective performance is illustrated in research by Deal & Kennedy (1982), who surveyed 80 companies finding that "of the 18 companies with qualitative beliefs or values, all were uniformly outstanding performers. . . . We characterized the consistently high performers as strong culture companies" (p. 7).

The apparent requirement for values and beliefs is not to deny the need for effective managers but a number of writers insist that the terms "leader" and "manager" should not be confused. Dubin (1979) expresses surprize at the confusion between leadership and management in stating,

> This is amazing. My knowledge of organizational behaviour has led me to the conclusion that effective organizations can be managed and supervised and not led, while some ineffective organizations can be led into their difficulties without the benefit of management or supervision. (p. 225)

Tucker (1981), links the concept of leadership to change in much the way as Hunt (1984b), who regards leadership as influence, and Kellerman (1984b) who describes a leader as "the one who makes things happen that would not happen otherwise" (p. 70). While management is essential to keep the wheels turning, leadership is about transcending the mundane, about reaching out for a vision. As described by Lunenburg & Ornstein (1991),

> Whereas managers are concerned with shaping the structures and processes of organization to produce desired results, leaders have a commitment or vision (a large view) and shape people around their commitment or vision. (p. 119)

Following the case study of three excellent schools Sharpe (1989) illustrated the need for this uplifting type of leadership in writing, "Organizations, like individuals, are much happier, healthier and better directed, if they can answer 'Where do you want to go? . . . Who are you? Where have you been? What have you to declare?'" (pp. 136-139).

Concern at the lack of emphasis on leadership and the confusion of leadership with management are addressed by Shalala (1989) in a similar way. In so doing she quotes from an advertisement in the *Wall Street Journal* which states,

> People don't want to be managed. They want to be led. Whoever heard of a world manager? A world leader, yes. Educational leader. Political leader. Religious leader. Scout leader. Community leader. Labour leader. Business leader. They lead. They don't manage. The carrot always wins over the stick. You can lead a horse to water but you can't manage him to drink. (p. 7)

Schein (1985), too, sees the value in differentiating between management and leadership and states, "Much of what is mysterious about leadership becomes clearer if we separate leadership from management and link leadership specifically to creating and changing culture" (p. xi). A similar position is held with regard to college presidents by Bennis (1990) who writes, "Perhaps the most important distinction between leaders and managers: leaders are people who do the right thing; managers are people who do things right" (p. 18). Comment by Foster (1989), in asserting that leadership and management are not the same, implies a similar moral overtone to Bennis' (1990) remark. Foster (1989) writes, "Leadership and management are not interchangeable. . . . Leadership occurs as a form of communal life concerned with how lives should be lived, not how they should be controlled" (p. 57).

Not all writers agree about the importance of this differentiation, however. For example, Rosenbach & Taylor (1989b), who state,

> A great deal of effort has been focused on separating leadership from management. We are not convinced this is a worthwhile endeavour. . . . The real issue is whether a group of people can achieve a common goal with the advice, assistance, and direction of an individual (or group). . . . What makes a difference is that someone helped them create a vision, energized the group to use the available resources for action, and kept the vision alive so that progress is made toward achieving the desired goal. (p. 2)

Bennis' (1990) answer is that we now have managers in the most influential positions in our society, not leaders who can help to create a vision. He claims that the lack of vision and direction in today's society is a reflection of "the national rebellion of the 1960s, the me decade that followed, and today's Yuppies are all consequences of the mistakes and crudities of the organization men" (p. 35).

While illustrating what these writers see as the difference between management and leadership, there remains, in a number of cases, overtones of a manipulative quality with some understandings of leadership. One example is Lunenberg's & Ornstein's (1991) statement that leaders should "shape people," a statement that has a distinctly manipulative ring and, in line with the criticism from Angus (1989), above, implies that the leader's vision is in some way superior and should over-ride other visions.

The development of a vision or the setting of direction is essential to leadership but, rather than being imposed upon members of an organization the vision-creation must involve and include members of the group in mutual interaction between them. Creating a vision, energizing people, and "doing the right thing" evoke images of mission and goals of a higher order conjured by Burns (1978), when he coined the term "transformational leadership." Burns' (1978) ideas about leadership have come to be of great influence in writings about leadership since the time that he coined the term "transformational leadership."

The Uplifting Nature of Transformational Leadership

Burns (1978) identified two types of leadership, *transactional leadership* and *transformational leadership*. There is relevance both to the discussion above about management and leadership and to that about the way the chief executives of different institutions operate. Burns (1978) defined the two terms in the following way,

> The relations of most leaders and followers are *transactional*--leaders approach followers with an eye to exchanging one thing for another: jobs for votes, or subsidies for campaign contributions. . . . The *transforming* leader looks for potential motives in followers, seeks to satisfy higher needs, and engages the full person of the follower. (p. 4, emphasis in original)

Key words that are found here include "motives of followers" and "to seek higher needs" which reflect Bass' (1960) concept of the task-oriented leader and the leader "being attracted to the group and its goals" and becomes involved in attempting "to solve the group's problems" (p. 154). Haddock (1989) describes an inspirational leader as one who, "Creates a climate of openness and trust. . . . For transformational leaders, the task is one of creation and commitment--creating a vision and then creating new meaning for organization members to secure their commitment to the new vision" (p. 186). Gardner (1989) makes the point that,

> The leaders we admire most help to revitalize our shared beliefs and values . . . [They] do not normally create motivation out of thin air. They unlock or channel existing motives. To accomplish that they must understand the hopes and fears and bread-and-butter needs of their constituents. . . . Effective leaders tap those motives that serve the purposes of collective action in pursuit of significant shared goals. (p. 26)

These aspects of leadership and the attainment of lofty goals comprise an important thread that runs through the literature of the 1980s and 1990s, including Burns' (1978) concept of moral leadership. Burns (1978) states,

> The result of transformational leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents. . . . Leaders and led have a relationship not only of power but of mutual needs, aspirations, and values. . . . Moral leadership emerges from, and always returns to, the fundamental wants and needs, aspirations, and values of the followers. (p. 4)

Burns (1978) has been most influential.

As can be seen, this concept is close to that of values-driven leadership used by Badarocco & Ellsworth (1989) discussed above. The "engaging the whole person" nature of transactional leadership being reflected or directly mentioned in research or overviews of research by numerous writers. Lunenburg & Ornstein (1991) write of the need for school administrators to "deal with the attitudes, values and motivations" of those in and involved with their schools (p. 121), Rutherford (1985) writes of "informed visions" and supportive school climates, Cunningham (1985) writes of "shared mission," and Doyle & Hartle (1985) refer to developing a school ethos which involves the teachers in a school becoming leaders (pp. 24-5). Smyth (1986) uses the term "transformative" in calling for "leadership that stimulates dialogue and mutual learning" (pp. 6-7). Sergiovanni (1991) describes the transition from from transactional to transformational leadership as stages in leader development (p. 123) and Rosenbach & Taylor (1989a) describe transformational leadership as "involving group members joining in a shared vision for the future" (p. 152).

Burns expands on what he meant by transformational leadership when he states in an interview (Goodwin, 1978), "In this engagement with their followers, the leaders' own motives are altered. . . . Both leaders and followers may be transformed to the point where followers become leaders and leaders followers" (pp. 47-8); in such a situation their occurs, in leaders and followers, a mutual growth. The impact of Burns' (1978) work is perhaps well illustrated by the comment from Bolman & Deal (1991) that

> whereas ten years ago managers were scrambling to learn how to be participative, now they are told that they must be transformational. Burns' distinction is a profound and useful one, but it is in danger of being transformed into another hula-hoop. (p. 437)

Haddock (1989) makes a similar comment in relating the concept to health administration in stating, "Transformational leadership may quickly be becoming a new 'buzz word' in the field of health care management. However if it is to go beyond the buzz word stage, ways of operationalizing its principles into organizational activities must be found" (p. 191).

The caustic comments suggest that "transformational leadership" may be regarded as something of a panacea for the problems of the world, from health administration, to schooling to business to politics. This is not the case and the thought may occur, at least partly, because of a limited understanding of what transformational leadership actually means.

As an illustration of this, Haddock continues on immediately from the quote above to say, "The creation and articulation of a new organizational mission will do little good without securing the commitment of workers and institutionalizing the implementation of the new mission" (p. 191), which gives the implication that the organization's mission is something presented to the workers by a superior, rather than having been developed in concert with them. If that is so, then " transformational leadership," as the term is used for the current study and as it has been argued for in this chapter, it is not.

The essence of transformational leadership makes explicit that leadership, culture, and group membership are intertwined, and is described by Foster (1986) as "praxis" which

> stands for the ability of all persons to engage in acts of leadership which help in the transformation to a way of life which incorporates participative principles; leadership, in this regard, is both critical and a shared leadership. It is shared because no one individual has the right way. (p. 14)

In commenting on transforming leaders, Kellerman (1984b) stated they "must draw on the group's culture" (p. 83) and Blowditch & Buono (1990) comment that "Transformational leaders also appear to have sufficiently strong empathy skills so that they tend to be quite accurate in the perception of others" (p. 181).

The concepts mentioned above are pursued by McPherson et al. (1986) who extend Barnard's thinking to suggest that leadership is in fact a shared phenomenon. Traditionally, much of literature has referred to "the leader" and has placed a sometimes explicit and often an implicit connection between leadership and position, a connection coming under increasing attack. Many of the attacks on traditional views of leadership have derived from feminist critique, which has criticized much of the literature on and research base for traditional conceptions of leadership for being positivist, sexist, and flawed in methodology.

A Critique of the Traditional Approach to Leadership

Much of the criticism of traditional approaches to leadership occurs from a feminist perspective or from the perspective of critical theory, or both. In using the term "feminist," as is pointed out by Noddings (1990), "it is . . . important to realize that feminism is not a unitary movement" (p. 393). As Young (1992) comments,

> Considerable uneasiness exists about the term "feminist," and misunderstanding of its multiple meanings. The uneasiness is derived, in part, from ignorance about feminism--that it comes in a variety of shapes and sizes; that it is relevant to the study of most subjects; [and] that it is an analytical and transformative perspective.
> (p. 20)

Notwithstanding the variety of views and stances that may fall under the rubric of "feminist" critique, Shakeshaft (1989) criticizes much of the research into leadership is "male-based theory and research [that has] . . . produced theories and concepts emerging solely from a male conscience [and] may be irrelevant for the female experience and inadequate for explaining female behaviour" (p. 324). Further, Schmuck (1987) asserts that "by paying attention to women as subjects and objects of study, scholars have found that the extant theories are no longer adequate" (p. 3).

In discussing her study of six women in senior administrative positions in Australian state education systems, Blackmore (1991) states that traditional perspectives of leadership suffer from "gender blindness" and

> propagate models of leadership which have come to be associated with gender-specific characteristics--assertiveness, independence, competitiveness, atomistic individuality, hierarchy, abstract rationality, and universal moral principles. There is no interrogation of the taken-for-grantedness of the autonomous individual and the division of labour, intellectual, and emotional work in ways which perpetuate the "gender-order" in society at large and the 'gender regime' within institutions. (p. 21)

In a stinging attack on the work of Maslow (1954), Cullen (1992) describes it as "gender-biased," writing,

> Self-actualization or self-fulfilment, being all that one can be, is the ultimate expression of the autonomous self, the male self that denies relatedness rather than the female self-in-relation (Chadorow, 1989), the self that thinks in terms of hierarchy rather than webs (Gilligan, 1982). (p. 1)

A similar concern with leadership research is expressed by Shakeshaft (1981), who conducted an analysis of doctoral dissertations on women in educational administration between 1973 and 1979. Shakeshaft (1981) concluded that "much of the research in this field is sexist" (p. 26), and"only three variables--the research issue, the feminist stance of the researcher, and the data-collection method--are significantly related to the quality of the dissertations" (p. 23). In proposing a paradigm for research on women in educational administration, she writes, "The research must grow out of the personal experiences, feelings, and needs of the researcher. It must explore the situation in order to understand and legitimize it as seen through the eyes of a woman" (p. 26).

The requirement for research to be within an interpretivist paradigm, as proposed by Shakeshaft (1981) above, brings to the fore the crux of feminist critique. Studies based upon a sexist perspective are worthy of criticism as a matter of principle, according to the feminist view, however this criticism is compounded when finding from non-representative samples are presented as universal and transferable. Shakeshaft (1989) comments,

> The harm comes not so much from the worldview but rather from the claim that it is the only lens through which to understand human behaviour. Studying male behaviour, and more particularly white male behaviour is in and of itself not a problem. It becomes a problem when the results of studying male behaviour are assumed appropriate for understanding all behaviour. (p. 325)

Criticism of such positivist research is also presented by Blackmore (1989) who writes,

> Implicit in the functionalist view of education was the epistemological assumption that scientific knowledge, gleaned through observation and empirical studies, was objective; that knowledge derived through scientific method could be generalized across situations, time and gender. In this way positivism and liberalism shared like views about the abstraction of the individual in order to universalize such experience. (p. 112)

Criticisms of a very similar nature are presented by other critical theorists, some of whom are feminists. In a paper in which she examines a number of ideas relating to female leadership, Lipman-Blumen (1987) writes, "One consensus point in the vast social-change literature is the difficulty in changing individuals, organizations, or society. The organizational problems women leaders confront require changes in all three areas" (p. 76). Smyth (1989) presents a similar view but does not restrict the issue to a concern of women only. He writes,

> Articulating a form of leadership that is more empowering of followers means moving considerably beyond the traits, characteristics and situations in which the standard view of leadership are contingent. It entails a preparedness to incorporate all school participants in an active and inclusive process of questioning, challenging and theorizing about the social, political and cultural nature of the work of schools. (p. 190)

The conventional approaches to leadership are described by Watkins (1989) as being "under attack from all fronts. Yet amazingly this highly questionable material is still included in standard texts. The reasons for this would seem to be based on ideological concerns and an attempt to maintain the power status quo in organizations" (p. 19). Whereas these critical theorist points of view are a subject of debate, I accept the view of Foster (1989) that "leaders, in short, create other leaders, and it is in this fashion that leadership becomes a shared and communal process" (p. 57). This aspect, that of leadership as a shared phenomenon, is the focus for the current study.

Shared Leadership

According to Van Fleet & Yukl (1989), in their overview of leadership research, "If one person dominates, a conventional view of leadership exists, but dual leadership is readily recognizable as well. If every member of the group shares equally (or nearly equally) in the process, then consensus or collegial leadership exists" (p. 76). Furthermore, in the view of writers such as McHenry, (1990), Kotter (1985), and Nadler & Tushman (1989) sharing leadership is not only possible, it is desirable. Indeed, Nadler & Tushman (1989) go so far as to say,

> Magic leaders, we call these heroes, and clearly they play a central role in revitalizing organizations. . . . How is it that some work magic while others foul? The answer: A heroic aspect is not enough. Unless a magic leader has developed complimentary leadership in the ranks below him, his efforts to create change may hardly disrupt the organization--or even wreck it. (p. 135)

The concept of leadership as a shared or complementary leadership has emerged through the middle and late 1980s and into the 1990s a new mode of thinking with regard to leadership through both the extension of previous thinking and as the result of extensive research.

One of the most influential researchers and writers in the 1980s and through into the 1990s has been Peters who, beginning with research into America's most successful companies (Peters & Waterman, 1982) writes, "A 'nice-to-do' in 1979 (when the excellence research began) has become a 'must-do' in the late 1980s" (Peters, 1987, p. 35). He writes,

> Today's successful leaders will work diligently to engage others in their cause. Oddly enough, the best way, by far, to engage others is by listening--seriously listening--to them. If talking and giving orders was the administrative model of the last fifty years, listening (to lots of people near the action), is the model of the 1980s and beyond. (p. 434)

The purpose of the listening is to identify people's needs and to empower them so that all can work together in "the pursuit of a commonly held dream, jointly defined" (p. 435). This idea was developed by Wentworth (1990), who proposes an inventory for school principals, which would include developing and encouraging a "leadership pool" and "encouraging everyone to use their leadership potential for the good of the school" (p. 4). Angus (1989) also refers to the importance of developing leadership throughout a school is stating,

> The capacity to exert human agency and engage in communicative interaction can lead to individual leadership acts being translated into collective rather than individual responses to pressing educational problems. School leaders, including principals, would seek to break from their bureaucratic rationality that encourages uncritical acceptance of established norms or organizational behaviour. Within this perspective, power and authority would be regarded as reciprocal, relational concepts. (p. 87)

In encouraging leaders to involve others Kouzes & Posner (1987) remind us that "Leadership is not a place, it is a process. It involves skills and abilities that are useful whether one is in the executive suite or the front line" (p.xviii). In so doing, managers need to remember the words of Bass (1960) when he states, "Anyone who is in a position to reward of punish will tend to become ego-involved in the role and gain personal satisfactions or dissatisfactions from merely playing the role" (p. 120). They need to be aware that the temptation to impose their views on subordinates in their organization makes their behaviour power-weilding, not leadership.

Fullan & Stiegelbauer, (1991) remind educational planners not to attempt to dominate the creation of a vision and limit others' ownership of plans when they write, "The more the planners are committed to a particular change, the less effective they will be in getting others to implement it if their commitment represents unyielding or impatient stance in he face of ineluctable problems of implementation" (p. 100). Kotter (1990) pursues this concept in stating, "People who articulate such visions aren't magicians but broad-based strategic thinkers who are willing to take risks. . . . What's critical about a vision is not its originality but how well it serves the interests of important constituencies" (p. 105).

The willingness and ability to involve others in leadership by inviting them to participate in the creation of a vision does not mean that leaders cannot exist in a bureaucracy. One of the participants from Blackmore's (1991) study of six women in senior administrative positions in Australian state education systems is reported as saying,

> Leadership doesn't come from the level of seniority and position. Seniority and position does give you more leeway to act. Leadership is helping to analyze what the situation is, so people understand what they are doing in one place and how it relates to or doesn't relate to what is going on elsewhere. (p. 26)

To dismiss all bureaucracies as inappropriate would be foolhardy and pointless, but Peters (1987), along with numerous current writers, calls for a change in the traditional, "top down" approach to management. He says that managers need to thrive on the chaos of their rapidly-changing environments, and Schein (1985) says, "The leader may not have the answer, but he must provide temporary stability and emotional reassurance while the answer is being worked out" (p. 318). Sergiovanni (1991) says, "Principals are important! Indeed no other position has greater potential for maintaining and improving quality schools" (p. 99).

Sergiovanni (1992) goes on to call for the involvement of all members in an organization and that, "When professional socialization, purposing and shared values, and collegiality are emphasized, they become substitutes for leadership. This means that direct leadership from administrators can be less intense--indeed much more informal" (p. 96). In a similar fashion, Bennis (1990) refers to a true a leader's task as being "to create not only a climate of ethical probity, but a climate that encourages people to learn to grow, prizes their contributions, and cherishes their independence and autonomy" (p. 146).

Conclusion

There remains some disagreement about the philosophy behind the concept of leadership as a shared phenomenon. Indeed, there remains significant support for traditional thinking and the making of a connection between leadership and position, such as is presented by Zaleznik (1989b) who writes,

> Quaint as it sounds today, the idea in the leadership compact is to support superiors, to try to see the world through their eyes, to do everything in one's power to help them do their job, and to make up for their shortcomings by diligently overcompensating for their weaknesses. (p. 17)

The equating of leadership with position is sometimes not far below the surface, for example Schein (1985) writes that "the leader needs both *vision* and the *ability* to articulate it and *enforce* it" (p. 317 emphasis in original) and at another point of a leader "imposed from the outside" (p. 322). Enforcing a vision on a group, it has been argued in this chapter, is not leadership at all, and "imposed leadership" is a contradiction in terms. Each is radically different from mutual stimulation between leaders and led and a vision which responds to people's basic needs!

In a critique of the traditional approach to leadership, Foster (1986) writes on some of the leading theorists,

> While these four studies [Selznik, Burns, Tucker, and Bennis] are a definite advance over the functionalist approaches to leadership . . . they still contain an implicitly hierarchical definition of leadership as a property possessed by some individuals. In so doing they do not approach the essence of leadership; they fail in the development of a critical spirit, which, in turn, is necessary for leadership; and they treat leadership as a volunteeristic trait, where one simply chooses to exert leadership. (p. 14)

The emphasis in the thinking on leadership appears to be shifting to the promotion of collaborative, complementary, or shared leadership by both theorists and practitioners. In a report on CEO selection trends in the 1990s Fulton (1992) writes, "Industries face with dramatic differences in their external environments are giving priority to CEO candidates who are experienced and comfortable with directing change over traditional management styles" (p. 31).

Traditional thinking is being increasingly criticized by writers such as Foster (1986), who writes,

> In short, the dominant means of studying hierarchical leadership has toppled under its own weight. It has produced little evidence and even less clarity. . . . The leadership idea should be reconstructed. The reconstruction is necessary not just because our research efforts bear little fruit. . . . The leadership we envisage is a critical leadership, one founded in praxis. To investigate this a new paradigm is needed. (pp. 7-8)

Kotter (1987) points out that many attitudes are ingrained as part of the socialization process when he states, "The development of leadership potential begins at birth. Attitudes and skills learned during the first five to ten years can make it easy or virtually impossible for an individual to play an important leadership role" (p. 185). How organizations are conceived and how the concept of leadership is regarded depends to no small degree on the world view of the individuals concerned. As Chisholm (1989) comments;

> Ultimately, choosing a centralized, formally integrated organizational system over a 'messy,' decentralized, informally coordinated multiorganizational system depends less on careful, pragmatic evaluation of relevant conditions and actual results than it does on a world view that emphasizes order, consistency, and apparent certainty and cannot tolerate overt disagreement and ambiguity. Such a world view also apparently values command and coercion over negotiation and voluntary agreement as mechanisms for bringing about coordinated action. (p. 196)

However, there is evidence that Foster's (1986) "new paradigm" is becoming more and more accepted. Barth (1990) comments, "I find that the concept of shared school leadership has become both fashionable and controversial. It appears that concerns about that relationship between teacher and principal, around school-wide decision making, will be with us for a good while. I hope so" (p. 122).

Even so, there remains much uncertainty and disagreement, and as Van Fleet & Yukl (1989) conclude,

> Research over this past century clearly demonstrates that leadership is not a simple, indivisible construct. It, like the atom, consists of a multitude of components each of which may have multiple characteristics. To some extent the answers we get depend on the questions we ask (Wheeler, 1977) but equally important, we are finding answers. Assuming there is "truth" in each answer, we, like physicists, need a Grand Unified Theory; unlike physicists, however, we may not have sufficient methodological rigor to expect a Grand Unified Theory Approach soon. (pp. 81-2)

There are common threads in issues addressed by earlier writers such as Argyris & Schön (1978), Barnard (1956), Bass (1960), Burns (1978), Herzberg et al. (1967), and Maslow (1954). Much of the work from these writers has been criticized as being elitist and sexist and of having a limited research base but did they did take cognizance of the points of view of others beside those in senior hierarchical positions in an organization.

Despite the weaknesses in their work--some of which can be explained in terms of the historical context in which they were conducted--these writers have been influential in some important ways, and they convey some similarity of thinking in the writings of a number of the most current authors such as Barth (1990), Bennis (1990), Blackmore (1989; 1991), Foster (1986 and 1989), Handy (1989a; 1989b; 1992), Kotter (1990), Fullan & Stiegelbauer (1991), Kouzes & Posner (1987), Peters (1987), Sergiovanni (1991 and 1992), Smyth (1989), and Watkins (1989).

While these writers do include those who call for the dismantling of status-quo organizational hierarchies, others call for the flattening of hierarchies, and others present a specific view on hierarchies, they do have the commonality of calling for the empowering of all members of an organization. Although there are sometimes massive disagreements between them, the commonalities in their thinking can be seen to build on much of the previous work on leadership and can be regarded as a logical extension in thinking from many of the previous writers.

CHAPTER THREE

Methodology and Theoretical Framework

Introduction

The foundation for this research lay within the interpretive paradigm. As described by Smith (1991), "The goals of the inquiry are the interpretation of meanings and intentions, and so on" (p. 6). Owen (1991) suggests the interpretive perspective is most suitable for a study such as the current one in stating, "Leadership, like all organizational phenomena, is ambiguous, irrational, deceptive, and unpredictable. Such an elusive phenomenon seems likely to benefit from the richness of an interpretive perspective" (p. 9).

As is advised by Field (1991), the questions for the study were "broad rather than specific, and the interpretation is rooted in the meaning the informant gives to events, rather than being rooted in . . . critical theory" (p. 99). The search for the answers to the research problem involved a qualitative research methodology. Such research has been described as naturalistic, concerned with actual events (Duignan, 1981; Guba & Lincoln, 1982) and the exercise of this type of research is described by Duignan (1981) as the attempt to "interpret the meaning of an event" (p. 285). In this chapter the theoretical orientation and framework of the study are explained, and the methodology for the research is described.

Theoretical Orientation

As suggested by Knafl & Breitmayer (1991) for research of this nature a variety of data was collected and a variety of approaches was used. Guba & Lincoln

(1982) assert that "there are multiple, intangible realities" (p. 23), a view that is accepted, and the attempt has been made to leave the way open for the readers to make their own interpretations and construct their own meanings from the research. This view is supported by Lather (1991), who states that "reality, it seems, is a text, subject to multiple interpretations, multiple readings, multiple uses" (p. vii) and the incursion of my world view on the research process is unavoidable.

To this end Chapter 1 contains a brief description of my background as the researcher and how the research came about. In this way, it is hoped that the reader will gain some understanding of my background as an Australian school teacher and principal and the perspective from which the research was conducted. As is commented by Shakeshaft (1981), "The research must grow out of the personal experiences, feelings, and needs of the researcher" (p. 26).

In accepting the existence of multiple perspectives, Adelman, Jenkins & Kemmis (1976) assert that a study should be presented in such a way that

> the reader should be allowed to reconsider for himself [or herself] the relationship between assertion and evidence. The overheard should be distinguished from hearsay, primary evidence from secondary, descriptive from interpretation, verbatim accounts from summaries. (p. 145)

Whilst allowing for these multiple realities, the research must meet what Guba & Lincoln (1981) refer to as "the criteria commonly used by scientific inquirers" (pp. 103-104). Authors such as LeCompte & Goertz (1982) identify the concepts of internal and external validity as being at issue. As described by these authors, "External validity addresses the issue of whether an independent researcher would discover the same phenomena or generate the same constructs in the same or similar setting . . . [and] internal validity refers to the extent to which scientific observations are authentic representations of some reality" (p. 32). While such objectives have obvious appeal, Guba & Lincoln (1981) believe that there are more appropriate terms for naturalistic approaches. They write,

> The four terms naming these concerns within the scientific paradigm are . . . internal validity for truth value, external validity or generalizability for applicability, reliability for consistency, and objectivity for neutrality. . . . We propose certain analogous terms as more appropriate to the naturalistic paradigm: credibility for truth value, fittingness for applicability, "auditability" for consistency, and confirmability for neutrality. (p. 104)

These four terms--"credibility," "fittingness," "auditability," and "comfirmability" are presented as main ideas for this chapter.

Research Methodology

The methodology required prolonged engagement, persistent observation, formal and informal interviews, peer debriefing, triangulation, and member checks (Guba & Lincoln, 1982, p. 247). The prolonged and persistent observation is a basic requirement for achieving the fullest understanding possible. The observations continued until the planning process for the health network had been completed. Interaction occurred during this time and throughout the data-analysis and report-preparation stage of the study.

The research was focused on investigating the exercise of leadership and the meanings attributed to leadership activity by the various participants. To assist in the addressing these issues the questions suggested as a general guide to qualitative researchers by Stainbeck & Stainbeck (1988) were found to be useful. These questions include;

> 1. What is happening, specifically, in a particular setting or settings?
> 2. What do the happenings mean to the people involved in them?
> 3. How are these happenings organized in patterns of social organization and learned cultural principles in the conduct of everyday life?
> 4. How is what is happening in the setting as a whole . . . related to the other system levels outside and inside the setting? (p. 15)

In accordance with the advice of these authors I endeavoured to "enter into the lives of the persons being studied as fully and naturally as possible" (p. 1) carrying with me the accompanying ethical considerations. As the first part of that process I operated in what Whyte (1984) describes as an "overt role" and he made it clear to all that I was conducting a study and was "prepared to explain what [I was] doing to anyone who ask[ed]" (p.30).

The most overt of the research activities were the formal interviews, which continued on an on-going basis throughout the data collection period. Numerous interviews were conducted with each of the participants following the methodology described by Brink (1991) when,

> the researcher tape records the interviews, transcribes them . . . [and] presents them to the informants, with literal transcriptions of the interviews. . . . Over time, the procedure is repeated with a number of informants, until by the end of the fieldwork period, the material is considered both valid and reliable. (p. 177)

The framework for the research is described below.

The Research Framework

Related to the research questions is the issue of a conceptual framework within which the study operated. Schein (1985) asserts that "*the only thing of real importance that leaders do is to create and manage culture*" (p. 2, emphasis in original) and that "culture is *complex* and difficult to understand" (p. 5, emphasis in original). In addition, the concept of leadership as a shared phenomenon is relatively new and the way in which it develops is not well understood and, consequently, I was presented with a number of challenges in preparing for and conducting the study. In that regard, the work of Pondy (1978) proved useful in creating the framework for the study. As Pondy (1978) describes the functions of leadership, they relate to the syntax--the connection of action and meaning--and he made the call for researchers of leadership to look further than the "observable, surface, stylistic components" (p. 90).

Pondy (1978) uses the analogy of language to describe the leadership process in stating,

> Grammar is the relationship between sound and meaning. In turn, grammar can be decomposed into phonetics, syntactics, and semantics. . . . To speak a language is to master all three components of grammar. . . . Suppose we think of leadership as a language. To practise, say, democratic leadership is to understand the set of meanings (values?) to be conveyed, to give them primitive expression, to translate them into stylistic representation, and ultimately to choose sounds and actions to manifest them. My worry is that this overarching process has been truncated, and we have reduced the grammar of leadership to its phonetics, the syntactics and the semantics of leadership have been lost sight of. (p. 89)

The conceptual framework shown in Figure 1 attempts to describe Pondy's metaphor, and forms a representation of how leadership functions. He urged researchers to seek deeper insights in a way that relates directly to the intent of the current study in commenting,

> What kind of insights can we get if we say that the effectiveness of a leader lies in his [or her] ability to make activity meaningful for those in his [or her] role set--not to change behaviour but to give others a sense of understanding what they are doing, and especially to articulate it so that they can communicate about the meaning of their behaviour. . . . Now some of these expressions refer to an internal, non-articulated sense of understanding. . . . If in addition the leader can *put it into words* then the meaning of what the group is doing becomes a *social* fact. That is terribly important! The meaning can be exchanged, talked about, modified, amplified, and used for internal processing of information. (p. 94, emphasis in original)

The essence of leadership is the way that meaning and behaviour are connected. Leadership is what leaders do to work with other members of the group to make the syntax, or in language terms the rules and understandings of the way meaning and action are related, into a common understanding. How this might be accomplished is investigated in the current study.

"Leadership as Language" as a Conceptual Framework

Leadership is shown by "those that go first . . . who step out to show the others the direction in which to head," (Kouzes & Posner, 1987, p. 32), it "relates to mission, direction and inspiration" (Fullan & Stiegelbauer, 1991, p. 158), and "leadership must be critical, transformative, educative [and] ethical" (Foster, 1989, p. 51). A leader will facilitate the process of the creation of common interpretations and connections similar to the way that Fullan & Steigelbauer (1991) describe leadership as the creation of common meanings, and to what Burns (1978) is addressing when he writes of transformational leadership.

Relating these meanings and the associated values to action, as addressed by Pondy (1978) in describing the leadership process, promised to be of great assistance in understanding the leadership process. A diagrammatic representation of Pondy's (1978) metaphor was consequently developed and this was used as the conceptual framework for the study.

The original version of the framework was modified during the study following my presentation of a paper on preliminary research findings to a meeting of health administrators. As a part of the presentation the conceptual framework was explained and following the talk one of the administrators asked if the three sections of the framework had a linear relationship. As I explained, the relationship between the three components of the framework is complex. The three sections of the framework are interactive and reflexive, in the sense of reflecting on one another, and the diagrammatic representation was not intended to show anything other than that. As a result of the conversation the framework was modified to the current form so that this complex relationship between the components is more clearly shown and leadership represented as the complex, value-laden, interactive concept that it is. The conceptual framework is shown in Figure 1.

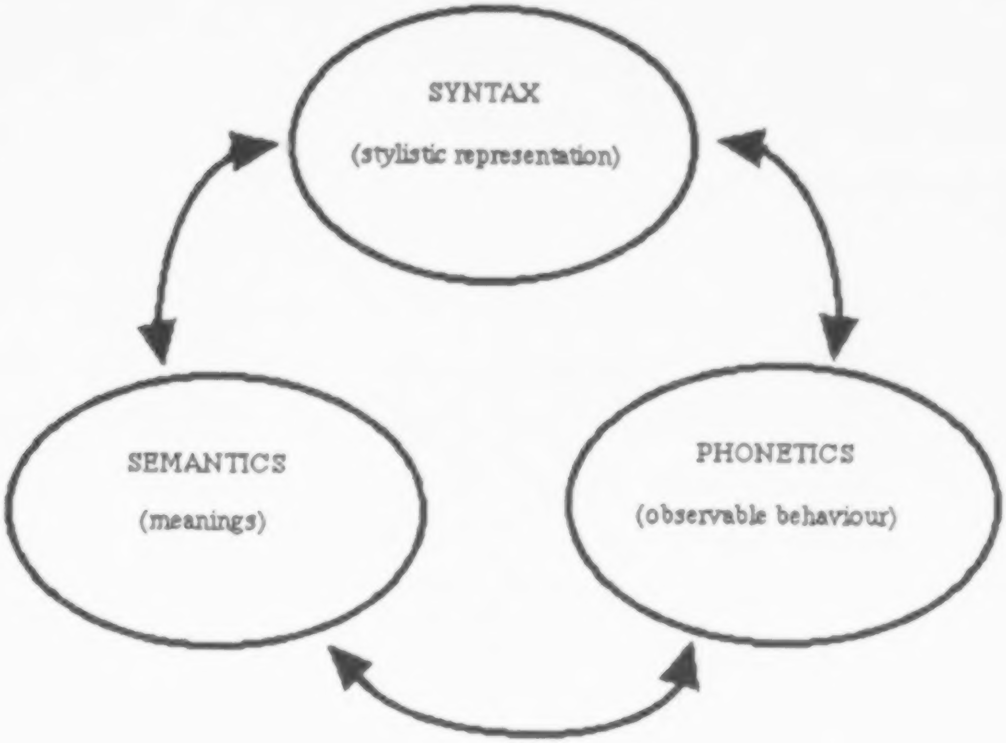
SYNTAX
(stylistic representation)
SEMANTICS
(meanings)
PHONETICS
(observable behaviour)

Figure 1. A conceptual framework: Leadership as language.

Developed from "Leadership as a language game" by L. Pondy, 1978, in *Leadership: Where else do we go?* 1978, by M. W. McCall & M. M. Lombardo (Eds.), Durham, Duke University Press.

This complex relationship between the components of the framework was illustrated in one of the most important events that took place in the study, when the group agreed to include the concept of area-wide health programs as a central part of the health network's operations. This incident is analyzed below, using the conceptual framework and is presented as an illustration of the conceptual framework framework in practice.

The Framework in Practice

When Patrick Smith, the Medical Officer of Health of the Timberwell Health Unit, introduced the concept of area-wide programs, he did so at a meeting of what was to become known as the Executive Planning Committee. The conceptual framework with its three components--semantics, syntax, and phonetics--helps to explain and assist in understanding what occurred in the process of the group discussing and accepting the concept for inclusion in the planning documentation for the health network.

Patrick began by presenting a document that he had developed following discussions with the Medical Officer of Health from a neighbouring health unit. He had modified and expanded ideas presented by his colleague into a two-page document entitled "Health Care Program." The first page of this document included text which identified a number of programs, the services that would be provided within each program, and the providing agencies that would be involved. The second page contained a diagrammatic representation of how examples of two such programs, the various agencies in the network, and the required support services would interrelate.

The "Health Care Program" document comprised the "stylistic representation" that would, in diagrammatic fashion, show how the value-set upon which the health network was based could be translated into the delivery of the various health services. In this way the text material and diagrams helped provide an understanding of what the members of the health network would be doing, and as such can be understood as comprising the syntax of leadership.

Having presented the concept, Patrick expounded on what the implementation of the health programs would mean. He talked of improved health service delivery and improving the provision of a continuum-of-service through inter-agency cooperation. These meanings and the values implicit in them and Patrick's vision of area-wide health programs was an expression of the values that were the basis of the health-campus concept which had been presented by Terry as the vision for the future of the health network. These values can be understood as being some of those that comprised the semantics of the leadership.

In promoting the concept of health programs, Patrick sought input from the other members of the group, and in so doing he approached the issue in a collaborative manner. This behaviour was a manifestation of the core values of collaboration, cooperation, and the sharing of ideas which were additional values to those identified above as comprising the semantics of leadership. Patrick's actions in the meeting, understood as the phonetics of the leadership, expressed core values of the health network. This relationship between Patrick's actions and the values behind them illustrates the reflexive relationship between the phonetics and the semantics of the leadership and how the sections of the conceptual model are interactive.

The three components of the conceptual framework--semantics, syntax, and phonetics--were thus expressed in this situation and assist in achieving an understanding of Patrick's leadership behaviour. In addition, this episode illustrates the manner in which each of the three components interact with one another. The leadership that occurred was shared, for although Patrick was the one "showing the way" he was suggesting a modification, through addition, of the vision that Terry had originally proposed.

As well, Patrick was inviting other participants to modify his ideas, but in the process of doing so presented a way in which there could occur a "transformation of consciousness" (as described by Foster 1989, p. 52) of what health-service delivery could mean if the health programs rather than the health agencies became the focus for planning. Through these interactions the shared meanings about the purpose of the health network were further developed. The seeking of an understanding of the way in which the participants arrived at a shared meanings was the essence of the purpose of the Richlands Health Network study.

Data Collection

The data collection for the study involved observation, formal and informal interviews, and document analysis. The observed behaviour was the phonetics of leadership, and discussions and interviews with the participants enabled the identification of the semantics of the leadership. Agreement about the semantics was a pre-condition for meaningful planning for the health network to begin because without agreement about the core values--the sharing of resources through collaboration between personnel from different health agencies--nothing of any consequence would occur.

What made the participants in this study unique was that they were able to come to that agreement and consequently their needs for organizational survival and the higher-order need for the development of a system for better health-service delivery could be addressed. Essentially, the study involved my investigation of the process of how a common understanding of the syntax of leadership was established, but as the study progressed and the interactive relationship between the semantics, syntax, and phonetics of leadership came to bear, it became clear that the process through which agreement about the semantics of leadership developed became essential to developing an understanding of events.

The observations were the first step in the data gathering but an essential and fundamental part of the study was to go past the observable behaviour and explore the meanings that the participants placed on the activities. This exploration was achieved through interviewing the participants both formally and informally, sharing the observations with them, and seeking the meanings that they attribute to the activities. The following section describes the study design through which this was achieved.

Research Design

Late in 1991, as a part of the course work in my Doctoral Program, I conducted a small study into the participative decision-making processes, attitudes, and understandings in a school. This study was reported in the form of a term paper early in 1992 and was used as a pilot study for the current research. The groundwork had thus been laid for the current case study to proceed.

As was discussed in Chapter 1, Timberwell Hospital was identified as a research site and access was negotiated in April 1992. The data collection was begun at that site in early July and expanded to include data collection at Timberwell Health Unit, Eaton Hospital, and the Timberwell Nursing Home soon afterwards. The study developed in three major stages: the exploratory stage, the focusing stage, and the data-analysis and report-preparation stage.

The Exploratory Stage

The first month or so of data collection required me to immerse myself in the hospital environment to learn as much a possible about the hospital culture. Initial interviews were held with Terry, the Chief Executive Officer; Bobby, the Director of Patient Services; Vincent, the Finance Director; Malcolm, the Medical Director; and Donald, the Executive Assistant. Each of these people were told of the general purpose of the study, and asked about the workings of the hospital and how they saw leadership in the hospital functioning. In addition, each was asked with whom they thought it was important for me to spend time with and to talk to.

In addition to speaking to the senior managers of the hospital, I also spent a considerable time in the hospital cafeteria and in the outdoor "smokers'" area. As the data collection began in mid-summer, many of the non-smoking hospital staff also spent their break times in the outside area enjoying the sunshine, rather than spending this time inside.

During this time an appreciation of many of what Schein (1985) terms the hospital artifacts was gained. These included the observation that the operation and management of the hospital was ostensibly governed by a large number of policy documents that related to the many aspects of hospital activity. How the non-administrative operations related to the policy documents was not addressed but it was found that the policy manual for the administration of the hospital was not a description of the manner in which the administration functioned. This was partly because financial constraints had resulted in staff changes and the organization charts in the manual identified some positions that no longer existed. Terry Neville, the Chief Executive of Timberwell Hospital, said that they were not concerned that the administration manual described the organizational structure that did not match the actuality because the administrators at the hospital were in the process of trying to develop a more participative and less bureaucratized organization and things would continue to change. In any case, the manuals did not have to be reviewed until the next hospital accreditation inspection which was not due for more than a year and a half.

The organization chart in the administration manual showed the different administrative positions, the line-management relationships, and the bureaucratic hierarchy, but in actuality the hospital operated in a less-bureaucratic manner. The most important variation was the existence of what was called the Senior Management Group, which consisted of Terry Neville, the Chief Executive; Bobby Kennedy, the Director of Patient Services (formally known as the Director of Nursing); Vincent Hampson, the Director of Finance; Malcolm Simpson, the Medical Director; and

Donald Scott, an Executive Assistant employed as an Acute-Care Funding Consultant. Rather than managing their departments separately, as would be expected in a bureaucratically organized organization, this group functioned in a collaborative manner and operated as a group of colleagues. The initial observations of these meetings showed that the leadership of the group was transferred from individual to individual, depending on the issue and the discussion at hand.

Other artifacts that were observed included the tendency of the people from the different sections of the hospital to take their break times together. The relatively small size of the hospital meant that interaction between people from different departments was commonplace and their was a general atmosphere that the hospital worked as a unit, rather than as a group of separately functioning departments. The housekeeping staff, the ward nurses, the Central Sterilization Room nurses, para-medical, and administration staff took their breaks as separate departments but there was a degree of interaction between staff from the different groups when they took their breaks at the same time. People from two or three different sections of the hospital could be expected to be seen at the one table and it was not unusual for them to be joined by one of the physicians who was taking a break. In addition to making these observations, by talking to a wide range of hospital staff, I obtained additional suggestions as to with whom I should talk. During this time data were collected through both formal and informal interview, through field-note taking, and through document analysis.

The document analysis included hospital administration manuals and other policy documents, minutes from Senior Management Group meetings and Hospital Board meetings as well as data from a public opinion survey that the hospital board had commissioned the previous year. The intention had been to spend the majority of the research time with Terry, the hospital Chief Executive Officer, but during this early stage of the study he took a short holiday. I took the opportunity during this time to conduct formal and informal interviews and to spend extended periods of time with

Bobby, the Director of Patient Services, through which I was able to obtain an insight into hospital operations from her perspective. During the first few weeks of the study the importance of the Minister of Health's regionalization proposal became evident, and the initial focus of the study was modified.

The Focusing Stage

As the study progressed Terry began spending an increasingly large amount of his time thinking and talking about the Minister of Health's regionalization policy. He and the other senior managers at the hospital spent much of their time discussing the issue both formally and informally and the Senior Management Group placed increasingly heavy emphasis on matters pertaining to regionalization during its meetings.

When meetings were arranged with the Medical Officer of Health from the Timberwell Health Unit and with the Administrator from the Eaton Hospital, to discuss the Minister of Health's regionalization policy and the possibility of forming a health planning network based on their health agencies, Terry attempted to ensure that I was able to attend. Increasingly it became obvious that the study should be of the attempts by the administrators from the three agencies mentioned above, along with the Timberwell Nursing Home, to form their own health network.

The data collection occurred through me following Terry and observing the activities in which he was involved as the process of creating the health region based on the towns of, initially Timberwell, and then Timberwell and the town of Eaton, proceeded. In addition to field-note taking, interviews were conducted with each of the participants on a regular basis, so that their perceptions and understandings of events could be investigated. Apart from the days when I had commitments at university, data were collected on a daily basis over a four month period, with on-site days decreasing from mid-October, by which time the major decisions had been agreed to and the planning was nearing its conclusion.

Data analysis was on-going throughout the focusing stage, with questions that arose being asked and clarification being sought on various matters in formal and informal interviews. As the study proceeded, the analysis became more and more intensive until the end of the focusing stage, when field-note taking ceased and the entire research effort was placed on data analysis and validation procedures.

The Data-Analysis and Report-Preparation Stage

I made sound recordings of all formal interviews and made the transcriptions myself. Although this was found to be very time consuming it was a valuable exercise because I was required to look at the data closely. An increasingly formalized analysis of the data occurred as a part of the transcription process. In a similar way, I reviewed my field notes of an evening, recording observations and posing questions and making other notes to assist in further data collection.

The "prolonged and persistent" observation discussed above could result in the collection of an enormous amount of data. The attempt was made to ensure that data useful to the study were collected, but data that did not appear to relate to the creation of the health network or to the relationships between the participants were considered extraneous and were ignored. This step was taken because it was impossible to collect, or to handle, all of the data that became available over the four months of data collection.

Thus arose the dual issues of data reduction and quality control. Attention was paid to the issues of salience or weightiness, credibility, uniqueness, and heuristic value (Elliott, 1990). An example of salience or weightiness was Patrick's description of the planning process as "leadership without bosses," a statement that was considered to be of such salience that it was included in the title of the study. In addition to data that I considered to be of salience, during discussions and interviews participants were asked what they thought was important data and if they considered that I had missed anything that should be included. As a part of this process, the attempt was made to uncover the meanings that the various participants placed on different events and issues as they developed.

The second issue, the credibility of data, is discussed below in relation to the trustworthiness of the study. By the time the data collection had ceased, in early November, the more intensive data-analysis process had begun. As the first step in this process, I constructed a detailed chronology of the case from the field notes. As the majority of the data that had been collected involved Terry, he was given the first, detailed, chronology and was asked to comment on the degree to which his recollection of events was similar to that recorded and whether any events he considered to be important were not mentioned or appeared to lack the emphasis they required. Terry was also asked to advise which pieces of data, if any, he did not want included in further stages of the study. There were no data that Terry wished to be excluded, and he agreed that the emphasis of the chronology was a reflection of the significance of case events.

As the first chronology included in excess of 100 one-and-a half-spaced pages of text, it was felt that it would be unreasonable to expect other participants to read it all. A second condensed chronology, of slightly less than half the length of the first, was made. This was distributed to the other participants and feedback sought in a similar way that it had been sought from Terry when he had been given the longer version.

After the participants were given the reduced version of the chronology and while they were being given the opportunity to read and reflect on it, the analysis of the interview material was begun. Each interview was re-read and recurring themes were identified. Notes on these were made in the margin of the transcripts.

Eighteen themes, or main ideas, were initially identified. They included topics such as "Participative Management," "Focus on People," and "Organizational Survival," but this number was reduced because in some cases they appeared to lack significance and others could be combined into composite themes. The identification of the themes proved confusing, however, because some of the emergent themes appeared to be contradictory to others. I found it difficult to make sense of the way in which apparently competing themes such as "Focus on People" and "Business Thinking," or "Sharing" and "Boundaries and Territorialism" related to one another and to the study as a whole.

The confusion about how to make sense of the data was not alleviated when the first-produced "long" chronology was analyzed in the same way and similar themes emerged. Discussions with the participants and with my peer-debriefing group led me to realize something that had been evident for a considerable time in the study and had been at the edge of my thinking without being identified as a central issue (the peer-debriefing group is discussed more fully below). I came to the realization that the variety of world views held by participants meant that their different perceptions of events affected their behaviour and their language and thus led to the emergence of a variety of occasionally competing themes.

The existence of these differing world views became a key in the development of the data analysis and as a result Chapter 5 addresses the issue of differing world views. Sandelowski (1986) suggests that the credibility of a study is established when the study "presents such faithful descriptions of interpretations of a human experience that people having that experience would immediately recognize it from the descriptions or interpretations as their own" (p. 30).

In order to check for credibility member checks were conducted. I took the drafts of the analysis chapters to each of the participants and discussed the contents of the draft chapters with them before leaving them to be read in detail. On return visits I had discussions on them. The interpretations and analyses were met with agreement, and in some cases enthusiasm, from the participants. They agreed that the chronology "made sense" and contained recognizable and tenable interpretations of the events of the case. These interactions established the credibility of the study.

The fieldwork and interview data and the documentation of the steps taken in the data analysis process have been retained and comprise the "audit trail" suggested by Guba & Lincoln (1981) and Sandelowski (1986). The issues of credibility, auditability, member checks, and the like comprise parts of the wider issue of the trustworthiness of the study, discussed in the following section.

Trustworthiness of the Findings

An important issue with regard to trustworthiness is the acknowledgement of the existence of researcher influence. Guba & Lincoln (1982) accept that "the inquirer and object interact to influence one another; especially . . . when the object of the inquiry is another human being" (p 238). In a similar way, Levey (1989) remarks that "the best data flows out of a relationship in which the informants trust the researcher and in which the researcher has a grasp of his or her own influence on the interaction" (p. 77).

The participants indicated that they felt that a relationship of trust was established between us in the study, which was my own perception, and they acknowledged that I had influenced the network-creation process. In an exit interview Bobby said that she could see that I was consciously making the attempt not to influence the participants and for the most part was successful but that she felt that my presence tended to make participants more considered in their actions, and in that regard I had probably been instrumental in making their actions more effective. My presence were seen by Bobby as having influenced the study.

Terry also said that I had been influential, feeling that he had learned "quite a lot" from the many discussions that we had had. Terry said that the establishment of the health network had occurred in the way it had because he had clarified concepts by discussing them with me. Indeed, to my surprize, in one conversation Terry said that I had suggested the term "partnership" by using it in a conversation in describing the relationship between the participants. "The term fitted, so I used it," he said. Terry said that my presence had almost certainly improved the chances of the group successfully creating the health network.

My presence is therefore acknowledged to have influenced events; however, this influence is accepted as being inevitable and could not be considered as having compromised the trustworthiness of the study. This trustworthiness was established through the persistent observation, member checks and other methods that are referred to above. In addition to these, however, was the use of triangulation and peer debriefing, the former being internal to the research and the latter being conducted separately from the research site and research participants.

Triangulation and Member Checks

There were two other methods of enhancing the meaningfulness of the interpretations. The first of these is described as triangulation (Guba & Lincoln, 1982; Jick, 1979; Stainbeck & Stainbeck, 1988). Triangulation involves the comparison of data collected using a variety of data collection techniques and from a variety of data sources. Triangulations is described by Jick (1979) as being of two types: "'Within-method' triangulation essentially involves cross-checking for internal consistency or reliability while 'between-method' triangulation tests the degree of external validity" (p. 603). Each of these was used in the current study.

Data were discussed with the various participants. These consultations allowed as full as possible a picture of events that I did not attend to be obtained through the consultation with each of the participants that had been involved and by comparing the perceptions of the different participants. In that sense, the participants performed as different data sources and allowed the cross-checking for triangulation referred to by Jick (1979).

The use of the different methods of data collections allowed for between-method triangulation. Data from field notes was compared with data from interviews and through the analysis of documents such as the minutes of meetings, described by Knafl & Breitmayer (1991) as the use of "a variety of data collection [sic] techniques (structured instruments, observations, and intensive interviews), which have been selected because each taps a different aspect or dimension of the problem being studied" (p. 234). The prolonged and intensive observation that was involved with the collection of the data also assisted with triangulation by facilitating the "capture [of] a more complete, holistic, and contextual portrayal of the unit(s) under study" (Jick, 1979, p. 603).

Related to the issue of triangulation is the contention of Wilson (1977) that data collection should be "multi-modal". The data should relate to

> 1. The form and content of verbal interaction between participants.
> 2. The form and content of verbal interaction with the researcher.
> 3. Non-verbal behaviour.
> 4. Patterns of action and non-actions.
> 5. Traces, archives, records, artifacts, and documents. (p. 255)

Important to the collection and verification of data were member checks. Member checks involved the discussion of data with the participants, to check that my perceptions of events, remarks and actions were agreed to by the participants.

Member checks, like triangulation and peer debriefing, were important in establishing what Guba & Lincoln (1981) term "truth value" and because it is accepted that my observations were clouded by my own values and theories, and my construction of reality formed a filter for my perceptions. Through these processes of member checks, like triangulation and peer debriefing, meanings and understandings could be clarified. In addition to member checks, interpretations of data were also discussed through the peer-debriefing process.

Peer Debriefing

As part of the research process, on-going discussions occurred through continuing meetings between myself and the members of my advisory committee. In addition to these meetings a peer-debriefing program was established. The peer-debriefing program involved the establishment of a mutual-support and discussion group comprising myself and five other doctoral students, each of whom was involved in his or her own research . Beginning in the spring of 1992 the group met on a weekly basis to discuss research methodology, research and other related literature, and aspects of the studies being conducted by members of the group. The members presented to each other issues relating to their own research and data from the current study and interpretations of it were among the issues discussed. Each of the group members was encouraged to challenge assumptions, hunches, and tentative conclusions presented to the group. This process provided a valuable checking mechanism through which interpretations of data were questioned and challenged from a variety of perspectives.

Members of the group include individuals with backgrounds in education, public administration, and nursing, and come from widely dispersed locations. The expertise, variety of backgrounds, and experience in the group continues to prove most valuable in enhancing the quality and credibility of the studies being conducted by the various members of the group. In line with the ethics guidelines, discussed below, the anonymity of the research sites and participants was strictly maintained during the peer-debriefing process.

Ethics Guidelines

From the outset, the primary concern has been the protection of the interests of the participants. Every effort has been made to ensure the protection of both their collective and individual anonymity. In the same way every effort was made to protect individual confidences during the study and I was prepared to omit data that could prove damaging to anyone involved. All participants were consulted and their agreement gained before any material was published. Part of the ethical requirements of the University of Alberta is the explicit right of any participant to withdraw from the research at any point and this requirement was adhered to. These ethical concerns were of great importance, given the nature of the research.

These considerations played a part in establishing site access. In addition to my desire to provide *quid pro quo* in securing access, as a researcher I feel that those that are prepared to participate in research have the right to be able to gain from a study. A copy of the research report will be made available to the participants and Terry has accepted my offer of what he terms an "executive summary" of the study. In addition, I will make himself available for discussions on the study or other related matters, when desired. Terry has accepted this offer and Patrick has already indicated that the study has assisted him in gaining important insights that he would not have developed otherwise.

Conclusion

The study was conducted using the interpretive paradigm. Data were collected over a period of four months with the data analysis beginning during that time and the data analysis and report writing proceeding continuously for an additional three months. The research was conducted paying particular attention to the issues of credibility, fittingness, auditability, and confirmability, identified by Guba & Lincoln (1981) as issues of concern in this style of research.

CHAPTER FOUR

The Case Study Chronology

Introduction

This chapter tells the story of the planning phase for the health network from its beginnings on June 19, 1992 and continues until the completion of planning on November 6, 1992. On different occasions a number of the participants compared the planning process to a courtship-marriage and the metaphor is used in the presentation of the narrative. The courtship period led to an engagement when the respective boards promised to continue planning together and this led to the marriage, when the boards formally agreed to a union in the form of the health network. The honeymoon period ended as the participants settled down to address some difficult issues in their organizations' new marriage.

As was described in Chapter 3, data were collected through observation and field-note taking, formal and informal interviews, and document analysis. The method used for the observation involved me spending the data-collection days almost exclusively with Terry.

Terry thus became the central figure in the data collection and the chronology presents him in that way but he did not work alone and he set out with the deliberate intention to not only involve others in the process of creating a health network. He sought to share the leadership in the planning process with them.

A number of the participants played important leadership roles. To assist the reader to follow the chronology, Figure 2, shows the main participants and their agencies.

Timberwell Hospital

Chief Executive Officer: Terry Neville
Director of Patient Services: Bobby Kennedy
Finance Director: Vincent Hampson
Medical Director: Malcolm Simpson
Executive Assistant: Donald Scott

Timberwell Health Unit

Medical Officer of Health: Patrick Smith

Eaton Hospital

Administrator: Warren Pritchard
Director of Patient Services: Beryl Sherrington

Timberwell Nursing Home

Administrator: Winifred Wychuk

Figure 2: Agencies and major participants in the Richlands Health Network.

Terry was a central figure, initially because the creation of a health network based on Timberwell and including Timberwell Hospital and Timberwell Health Unit was his idea. In addition, he presented the concept of a health campus as his vision for the health network. Warren initiated formal contacts to discuss Eaton Hospital becoming a part of the health network, and both Donald and Winifred played important roles in Timberwell Nursing Home becoming a member. Donald was also most important in guiding the planning process through the initial stages and his leadership and management skills were particularly valuable. Patrick Smith played a vital role, initially because he was the first to agree to consider the creation of a health network through working with Timberwell Hospital, and he became a key leader in the planning process. He proposed the important modification to Terry's vision of a health campus with the concept of health programs as the focus for the health network and played a leading role in the development of the organizational structure for it.

Patrick and Donald wrote the original proposal document and it was Patrick's vision of a health network based on health programs that was a major modification to the health campus concept originally proposed. This innovation changed the focus of the planning from health agencies to health programs. Another very important leader was Bobby, whose quiet behind-the-scenes communication skills tended to bind the participants together, and she communicated with people not directly involved in the planning process by keeping them aware of what was occurring.

The Courtship

The events of the case began immediately after the Minister of Health's announcement that the health system was to be regionalized. On the way home from the meeting at which the announcement of the regionalization policy was made, Terry Neville suggested to Patrick Smith that a health region based on the Timberwell Hospital District and consisting of their two agencies would meet the Minister of Health's criteria and that they should consider forming a region of their own. At this time health administrators around the province embarked upon negotiations in the endeavour to come to agreements as to which facilities would work together in creating the area planning networks called for by the Minister of Health.

Soon after the Minister of Health's announcement of the regionalization policy administrators from a group of health agencies in the general area of the town of Timberwell, including Eaton Hospital, Marwell Hospital, Big Deer Hospital, High Valley Hospital, and the Marwell Health Unit held discussions with regard to them forming an area planning network.

Figure 3 shows the relative positions of the locations that appear in the chronology.

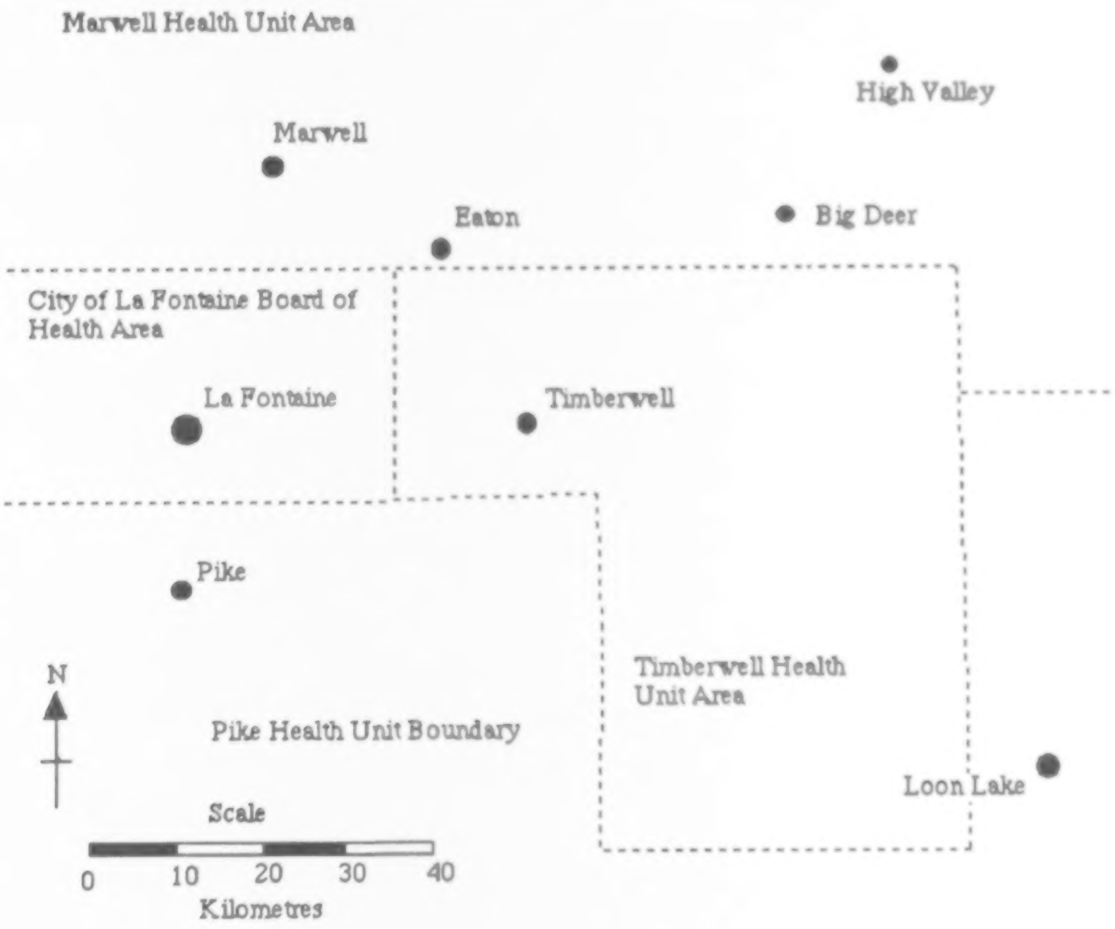
Marwell Health Unit Area
High Valley
Marwell
Eaton
Big Deer
City of La Fontaine Board of Health Area
La Fontaine
Timberwell
Pike
N
Pike Health Unit Boundary
Timberwell Health Unit Area
Loon Lake
Scale
0
10
20
30
40
Kilometres

Figure 3: Timberwell and environs.

The meetings were organized by the administration from Marwell Hospital and it appeared that they considered a region based upon Marwell Hospital and the Marwell Health Unit and including the nearby smaller hospitals at Eaton, High Valley and Big Deer a natural development. Representatives from Timberwell Hospital were not invited to attend the initial meetings, partly because the Marwell administration did not appear to consider Timberwell to be a part of their naturally-occurring regional group.

Comment from administrators from Eaton Hospital subsequent to these initial meetings suggested that an additional reason for Timberwell Hospital administrators not being invited was that the Marwell administration appeared desirous of taking the smaller hospitals over. The involvement of Timberwell Hospital, with its large number of patient discharges each year and the relatively large number of physicians holding privileges, stood to threaten Marwell Hospital's domination of the facilities in the region.

Warren Pritchard, the Administrator of Eaton Hospital, felt that Timberwell Hospital should be involved and ensured that Terry Neville was invited to subsequent meetings. Terry did not attend, sending Donald Scott, an Executive Assistant from Timberwell Hospital, as his representative and in addition, Bobby Kennedy, the Director of Patient Services at Timberwell Hospital, engaged in informal discussions with Beryl Sherrington, the Director of Patient Services at Eaton Hospital, about possible cooperation between the two hospitals.

Terry took no part in the formal discussions between the Eaton and Timberwell hospitals because he said, in referring to those from Eaton Hospital, he did not want to "scare them off," but did have informal discussions with Warren Pritchard. In discussing the proposal for an area planning network Terry presented his vision of a health campus as a possible basis on which the new organization could be built.

The major events of the courtship period are shown in Table 1.

Table 1

Time-Line for the Courting Phase of the Richlands Health Network Planning Process

- **June 19** -- The Minister of Health announces the policy of regionalization.

  -- Terry Neville, CEO of Timberwell Hospital, suggests to Patrick Smith, Medical Officer of Health at Timberwell Health Unit, that a region based on the town of Timberwell would fit the Minister of Health's guidelines for area planning networks.

- **June 19 - July 7** -- Initial discussions on regionalization are held between various agencies, including Timberwell Hospital, Eaton Hospital, Marwell Hospital, Big Deer Hospital, High Valley Hospital, and the Marwell Health Unit.

- **July 8** -- Timberwell Hospital executives discuss regionalization and prepare a time-line for preparing a regionalization proposal. The time-line is accepted by the Timberwell Hospital Board.

- **July 13** -- Patrick Smith agrees to specific discussions with the view to forming an area planning network involving Timberwell Hospital and Timberwell Health Unit.

  -- Warren Pritchard, Administrator of Eaton Hospital requests a meeting with Terry Neville to discuss the formation of an area planning network involving Eaton Hospital and Timberwell Hospital.

  -- Timberwell Hospital executives agree to invite the participation of Winifred Wychuk, Administrator of Timberwell Nursing Home, to take part in regionalization discussions.

- **July 15** -- The initial regionalization meeting between the chief executives from Timberwell Hospital, Timberwell Health Unit, and Eaton Hospital is held and it is decided to proceed with discussions on forming an area planning network based on those agencies and Timberwell Nursing Home. A copy of Community *Health Campus: Draft* is included on the agenda for the meeting.

- **July 16 - July 29** -- Donald Scott, Executive Assistant at Timberwell Hospital, liaises with Winifred Wychuk and Warren Pritchard, and works with Patrick Smith on an area planning network proposal.

- **July 29** -- Patrick Smith proposes area-wide health programs for inclusion as the focus for the health network being planned. The planning group, which became known as the Executive Planning Committee, agrees with the idea.

- **August 5** -- Executive members of the boards from Timberwell Hospital, Timberwell Health Unit, Eaton Hospital, and Timberwell Nursing Home agree that the preparation of a proposal for an area planning network based on their four agencies should proceed.

These meetings had been occurring for a a period of two or three weeks when data collection for the current study began. One of the first formal meetings I attended was a meeting of the Timberwell Hospital Senior Management Group, on July 8 and it was at this meeting that it began to become clear to me just how important the Minister of Health's regionalization policy was to the participants and the operation of the hospital.

The Timberwell Senior Management Group Discusses Regionalization

On July 8, at a meeting of the Timberwell Hospital Senior Management Group, Donald took the initiative in a discussion on regionalization. He reported having met with the Chairman of the Board and a Trustee from Eaton Hospital and stated that the Senior Management Group should aim at getting what the boards and the physicians wanted. "We have to work out where we want to go and where the administration [of Eaton Hospital] and the physicians stand," he said.

The discussion included specific mention of *Community Health Campus: Draft,* a document that Terry had prepared some eighteen months previously. Terry had proposed the health campus concept as his vision for the future of health services based around Timberwell. The document had been accepted in principle by the Timberwell Hospital Board and Terry now proposed it as the vision statement for the proposed regional health network. Terry did not present the health campus as *the* way that a health network should operate but as *one* way that the area planning network could develop, saying that the concept should be modified or replaced, according to the needs and ideas of other participants. Whether the hospital at Big Deer and High Valley Hospital should be included in any prospective region was also discussed.

In referring to *Community Health Campus: Draft*, Donald said, "We have to get the boards to agree on the function of a new facility," and with regard to the regionalization process Bobby suggested that an important role for Terry would be liaison with the city hospitals. Those present also agreed that because of the importance of the regionalization process the Senior Management Group should meet more often and an agreement was made that the group would meet again the following Wednesday.

The Timberwell Hospital Board Accepts a Time-Line

That evening at the meeting of Timberwell Hospital Board a time-line for regionalization prepared by Donald, at Terry's request, was accepted. The Board indicated a desire to merge with Eaton Hospital, and wanted to discuss the issue with representatives of Big Deer Hospital, but no mention was made of High Valley Hospital--presumably because the members of the Board felt that High Valley was too far from Timberwell to make its inclusion in a region feasible. The Timberwell Health Unit was mentioned as being a "key player" in the regionalization process.

The following week Donald and Terry discussed the inclusion of the Timberwell Health Unit in the proposed region. Donald reported having had discussions with Dr. Smith and that he had an "understanding" with him. He reported Patrick Smith's opinion that the Minister of Health's parameters for regions were too small. Terry commented that he would like to "sell him on the partnership idea," and said,"The ambulatory model is something that Provincial Health will buy."

Approaches to Dr. Smith and a Search for Allies

As discussions on creating a health planning network progressed there was a development of relationships between Terry and Patrick, and between Terry and Winifred Wychuk, the Administrator at the Timberwell Nursing Home. Each of the agencies had traditionally been funded and operated as independent entities, and to a large degree the courting period involved a testing of intentions and motives and the development of trust between the various participants. An important issue relating to the relationship between the participants from the different agencies was the variations in the status positions in the health system that he agencies were perceived to hold. Terry worked hard at emphasizing that the group consisted of "equal partners" and that differences in agency type and services provided, the volume of the services provided, and differences in funding levels should be ignored.

Donald and Terry were discussing their involvement with Patrick and the way in which they could best work with him. Terry agreed that an aim was to amalgamate the boards of the agencies involved into one board and then went on to describe what he saw was needed. He said, "We should push these issues so that we can pool, shift staff around and make the most of our manpower utilization."

"We've got to create a vision with Dr. Smith. We must push the whole agenda of a joint medical directorship. He'd do a better job. We could save money by sharing. . . . I want to sell Dr. Smith on this campus thing . . . and tell him we'll mould it to fit him."

There followed a discussion on the proposed region's relationship with the city hospitals, and the need to liaise with them. Terry commented that they should meet with John Holt, the CEO of the Amalgamated Hospitals Group, but that they must not do so until they had a plan. "If we were to go to the city without a plan we'd get gutted!" he said. He said they would be best off if they made just one alliance with city hospitals, even though that was a risk. "You have to take risks with one alliance. That gives you the best chance. You also have to talk to your doctors, they're an important part. We should have our own region, with liaison [with the Amalgamated Hospitals Group]. . . . We've got to let the doctors make a good living so they'll provide the services."

Terry talked of meetings with the others involved in the discussions on forming a region. "I don't want to go in and say, 'This is my agenda.' I want to get the creative juices going. I'd like to move into home care." Donald, an expert in acute care funding, declared that if that happened then they would lose funding "in a big way." Terry replied, "We need to get them to use our facilities, to cut duplication if they don't want to lose beds. . . . I say, 'Let's be proactive.' Dr. Smith understands. I had a two-and-a-half hour phone call with him on Friday."

The conversation was interrupted by a telephone call from Warren Pritchard from Eaton Hospital, asking for a meeting. Terry said that he would ask Patrick Smith if he would like to go. He also said that he thought it would be worthwhile if Donald and I could also attend, however Warren said that he was not happy with others attending the meeting, preferring to meet with Terry in private.

Eaton Hospital and the Health Unit Join in the Planning

Shortly afterwards, Terry, Patrick, and Donald met in Terry's office. Donald stated that there were two issues--whether the boards wanted to be involved, and what other facilities did they want to have involved.

There was a general discussion about the prospect of creating a region based on the towns of Timberwell and Eaton. Terry spoke to his vision of creating a health campus and Donald reported on the doctors' generally favourable attitudes to the hospital merger. Terry commented, "I've realized that the doctors are easier to get on with because of this [regionalization]. The doc's have a major influence because they are the grass-roots people."

After Patrick left, Bobby joined Terry and Donald and they discussed ways in which Timberwell Hospital's administration could arrange discussions with Winifred Wychuk, the Administrator of Timberwell Nursing Home. There was a problem relating to a possible personality clash between Winifred and Terry. Donald and Bobby discussed the plan that they had previously worked out between themselves, whereby Bobby would do the negotiating, with Terry. He agreed with the plan, but said that he should first contact her to gain her agreement, as she may, as CEO, be offended if she was to negotiate with someone below that level. All agreed. This discussion was followed by a three-way sharing of ideas on possibilities for the proposed region and Terry asked that Donald make time to explain to the Health Unit staff how hospital funding worked, pointing out that he was looking for ways that they could help the Health Unit in its business.

Another Addition--The Timberwell Nursing Home

Early next morning Terry reported to Bobby and Donald on a telephone conversation that he had had with Winifred from the Timberwell Nursing Home. He had made the call as had been agreed, but Winifred had wanted to discuss the issues with Terry rather than Bobby as had been planned. The feared conflict between Terry and Winifred had not occurred. When Terry reported to Bobby and Donald about his meeting Winifred he was clearly delighted with her high level of desire to cooperate and be involved in the regionalization process.

Later, on July 15, at a Senior Management Group meeting, Terry commented that it was important to make the physicians aware of the issues involved with regionalization. Donald posed questions such as, "What is the final goal [of regionalization in this area]? A new health campus by this time next year?" He also asked about the implications for the staffing of the hospital, particularly with regard to administration. In discussion Donald drew a proposed organizational structure diagram and possible participants in a planning network on the white board of the conference room. He expressed the view that the High Valley and Big Deer hospitals should not be included in the diagram. "We should make it small and attractive," he said, and sought input for the diagram from around the table.

Terry's comment was, "I'd like to phase things in. To work on the relationships with the others then move on." Donald continued to pose questions, including whether discussions should be at CEO level or whether input from the directors of nursing should be sought. He asked about time-lines and the involvement of the boards.

Terry indicated that the political considerations were very important and, that the potential participants "all need something that they can have ownership of." He asked Donald to seek input into the *Community Health Campus: Draft* from the other CEOs. As the meeting concluded, Terry asked Donald to prepare a copy of his organizational structure diagram to present at the meeting of CEOs to be held at Eaton Hospital.

The preparation of a proposal is begun. The following morning at a meeting between Terry and Donald the issue of regionalization was being discussed. The CEOs had met the previous night. Terry said he thought Warren was looking at what he could gain for his hospital and had talked about board composition the most. Donald sought clarification as to whether they were looking at a merger of the hospitals or at the type of region envisaged by the government. "If you look at the letter from the Minister, we're doing what the government wants," said Donald. "But he [Warren] was looking at programs."

Donald pointed out that they were embarking on a participatory process that was near to but not exactly like the government's regionalization. Conversation moved onto the preparation of a formal proposal document and Terry said, "We need to use the word 'creative' at least five times in the proposal. We need to involve Bobby and Vincent in the meetings so that we can get their ideas and start to put them together." He said that the term "participative" should be used rather than "merger" and that the goal should be "to give each institution identity, but to work collaboratively with a central function managed by the CEOs collectively."

Donald wanted to know whether Terry had shown Warren the diagram. Terry said he had, and that Warren wanted day surgery, to which Donald replied, "We can give him one [program]. Which one?" Terry said that they should wait. Donald pointed out that Dr. Simpson did not want physicians to have privileges at both hospitals and that in planning they should be program specific.

Terry referred to the political considerations involved in reaching a satisfactory agreement and said, "One of my goals is the need to move to a total management structure. . . . I want to get more people involved, to involve the people that can make it work. We should form a strategic planning committee with others on it."

Donald asked whether he should include *Community Health Campus: Draft* with the agenda for the next CEOs meeting. Terry said, "Yes. . . . I'd like to see the health campus concept made as a role statement." He asked Donald to be the facilitator of the regionalization process. "We'll take your time out of Acute-Care Management," he said. "And get some help with setting up the agenda. . . . The directors of nursing also want to talk. We're talking about protecting the social service," he said. "When you look at strategic planning you've got to look at the threats."

Discussions on how to involve Winifred in the planning. Terry and Donald were discussing how to proceed, how to involve Winifred in the regionalization process, and the best way for the two hospitals to work together. Terry suggested that emphasizing the business function might be the best way to begin, and then talked about the setting of a broad direction. "We will discuss the Minister's direction and commitment, and then we can discuss where each of us wants to go. I'd like to know how far Winifred can go on decisions," Terry said. "Dr. Smith will probably tell us how far he wants to go before going to the boards. . . . And we really do have to include the doctors."

Terry said, "I'm talking about broad policy to be decided by the boards. I'm talking about a good finance system. We could sell that to the doc's." Terry told Donald that he should go through the agenda with Winifred. "No," said Donald. "She's only ready to listen."

Terry replied, "After speaking to you, I think we should discuss this with Warren, to see what areas we might share. Perhaps we should have a joint senior management meeting first. Warren and I should be involved with the process, not what's happening. When we get the boards' approval we should set a process up based on the Amalgamated Hospitals model."

Donald commented that he thought that Winifred would be more comfortable chairing a more focussed meeting. "She regards this as an information-sharing meeting," he said. They agreed that Terry would contact High Valley and Big Deer hospitals to inquire about their plans.

The CEOs met on Friday July 24 and were positive about having the facilities work together. Terry stated that what was needed was a "vision, to take risks." Winifred agreed with those sentiments. Patrick Smith and Warren Pritchard showed a desire to address matters of practicalities. Those present agreed that they would approach their boards with the proposal and seek a reaction. There was agreement that terms such as "community good" and the moving away from focussing on boundaries was a positive thing and Patrick said that he imagined that all the health-related agencies centred on Timberwell could be involved. Emerging from the meeting was the consensus that the process that those present were embarking on had merit regardless of the regionalization issue.

Health Programs Become Part of the Vision

The following week, Winifred, Terry, Donald, Patrick, and Warren met to continue the regionalization planning and to prepare an agenda for the meeting they would have with representatives from each of the facilities' boards the following week. This planning group was to become known as the Executive Planning Committee.

Prior to the meeting formally beginning they discussed how the administrator and the Board at Marwell Hospital had been "taken aback" when they heard that Eaton had begun negotiating with Timberwell. Warren stated that he thought it was "too early to make decisions" but explained that in negotiations the Marwell Hospital administration had seemed to appear to have the attitude that they would be taking over Eaton Hospital . Terry picked up on this theme saying that the group members needed to be open with each other and establish a position of trust.

Patrick arrived with a document including a diagram for health promotion that he had been given by Dr. Baldwin from the Marwell Health Unit. "I've incorporated some of the things I gave you, Donald," he said. Patrick stated that the approach was based on a "we'll-help-you" rather than a "we'll-do-it -for-you" approach. Patrick suggested that they focus their thinking around the concept of health programs rather than the traditional approach of focussing on facilities. Patrick's vision of a health network based around the health-program concept was accepted by the group. This represented a significant development in the thinking on the health network and was an important modification to the vision of a health campus that Terry had proposed.

Donald indicated that there was only one item for the meeting to consider: what to present to the boards at the joint meeting to be held the next week. Donald referred to the draft regionalization document. "We're trying to change the focus to 'what's best for the community' rather than 'what's best for the facilities,'" he stated. "What direction do we want the board meeting to go?"

Terry moved to the white board and made notes on what was discussed, forming an agenda for the meeting with the combined boards. They agreed that the regionalization issue should be discussed in only general terms. Patrick said, "This meeting is to ask the individual boards for their blessing for us to continue meeting and planning, and to get from the boards a commitment that they will continue to talk."

They discussed the boundaries and all agreed that a boundary that encompassed the facilities now involved would be one with which they all were happy. The rivalries between the group members and the Marwell Hospital and the Marwell Health Unit were addressed. "That's why we need to support each other," said Terry. Patrick addressed the issue of health units encompassing planning units, to which Terry agreed that they should be prepared to work with others. These comments led to Patrick referring to the organizational diagram. "We don't need to worry about support services," he said. "We should look at the programs. A fundamental structure is not about support services, it's about programs." Donald said with regard to the draft, "We should expand the draft with more examples, incorporating the vision statement with area-wide programs."

After considerable discussion they came to an agreement on an agenda. Donald, who was taking notes, described them. "So we'll wait for the process until after October 6th," he suggested. "If we get their blessing we can meet more before October 6th [the date on which the proposals for planning networks from the La Fontaine area were to be presented to a meeting with Provincial Health officials], and do more detail," proposed Patrick. "We'll be far ahead," concluded Donald. Warren observed, "If this [regionalization process] didn't occur we should do this anyway. We should have been doing this a long time ago."

The formal meeting finished and Patrick, Terry and Warren discussed various issues before leaving the meeting room. Terry expressed concern about the attitude of the physicians, and asked Warren how the doctors at Eaton were taking the regionalization issue. "I've talked to them . . . " said Warren. He did not elaborate but gave the impression that he was having difficulty obtaining their support. "We have to get the doc's involved," said Terry. "I've written to Malcolm Simpson asking for someone whose positive [in attitude to the creation of the health network]."

"I'll talk to the doc's, too," suggested Patrick. "They'll listen to you," said Terry, and then added, "We should get the positive ones involved."

The Engagement

The Executive Planning Committee met with representatives from each of the agencies' boards the following week. The board members were presented with an overview of the Minister of Health's regionalization policy and a synopsis of activity that had occurred in that part of the province to that date. The document prepared by Donald, in consultation with Patrick, was presented to the meeting.

All boards represented indicated an interest in pursuing the possibility of establishing a health region based on the Timberwell-Eaton area. The agreement that planning for the region should continue was similar to an "engagement to become a network." The "engagement" period was the time of planning and that led to the agreement from representatives from the boards of each of the agencies on the final proposal document to be presented to the Minister of Health.

The major events in the period leading up to the reaching of this agreement are shown in Table 2.

Table 2

Time-Line for the Engagement Phase of the Richlands Health Network Planning Process

- **August 13** -- Health programs suggested by Patrick are added to the proposal document.

- **August 18** -- Administrators and representatives from Marwell Hospital meet with Terry Neville and the Timberwell Hospital Board Chairman to discuss Marwell Hospital becoming a part of the Eaton/Timberwell area planning network.

- **September 2** -- Terry meets with John Holt, President of the Amalgamated Hospitals Group to talk about the plans for the area planning network.

- **September 3** -- Board representatives from Timberwell Hospital, Timberwell Health Unit, Eaton Hospital, and the Western Province Long-Term Care Organization (the organization of which the Timberwell Nursing Home forms part) accept the area planning network proposal document.

In the weeks following the agreement by the boards that planning for the health network should proceed Terry and Donald met a number of times. On one occasion Donald reported on the hospital's funding problems. "The health campus idea would solve this, if we cooperated with Eaton Hospital and Timberwell, the long-term patients could be taken from our beds and they could become day-use beds," he said. Terry pointed out that they needed to gain the cooperation of the doctors if they were to overcome their funding problems.

Terry described their proposal as "really a sales document. We have to sell it to government, to give them lots of reasons to approve it. We have a good package." They agreed that the major advantage that they could show was that their network represented a totally integrated health system, and that if the region was too big then the high degree of integration would not be possible.

Once again, Terry referred to the politics of gaining support for their idea in strategically significant quarters. "I'll have to get Patrick into my network [of contacts with significant people in the health system around the province]," he said. "I'm [annoyed]--it took me ten years to set it up, but if they [the others in the health network] are to be equal partners they have to have equal partners. It's a bit of a threat to me," Terry concluded.

In response to the wish of Warren, they agreed to arrange a meeting of department heads from the two hospitals. Which departments to include were discussed. Finance was one mentioned. "We can't integrate delivery of care, but we can integrate support," said Donald. "The CEOs could make that a goal," said Terry, to which Donald replied, "We should make a mention of the *Community Health Campus: Draft* in our document." Terry agreed.

The Executive Planning Committee met again on Thursday, August 13 at the Timberwell Hospital business office. Patrick had brought with him a list of possible health programs to be included in the document. Terry pointed out that the health campus concept that was being pursued in Timberwell/Eaton was different from what was occurring elsewhere and that it was possible that a redirection of resources would mean some agencies might lose out.

Beryl, representing Warren who was on holidays, reported that she had met with the CEO and board representatives from Marwell Hospital, at their invitation. The Marwell Hospital people had asked about becoming part of the proposed network, and Beryl said that her hospital wanted partnership from other group members, not leadership. She said that she could not speak on behalf of Timberwell Hospital, or any other of the network members, and that if the administrators of Marwell Hospital wanted to find out what the Timberwell Hospital people thought of them joining, they should ask them.

Patrick said, "We have a concept. It was Terry's idea. We don't have to talk about boundaries or governance. There's no threat to members." Terry said, "This is participatory management, like I'm trying to do in the hospital. . . . My feeling is that it works in the hospital," he said.

The conversation continued around the theme of regionalization in general and the possibility of Marwell Hospital becoming involved. Patrick commented, "We'll keep the network regardless of what happens [with the regionalization process]."

"What we actually have," said Patrick, "is an inter-agency corporation around the health program."

"You could turn the list around and people could list the agencies that would be involved," said Terry. "It's three dimensional; agency--program--institution."

Discussion flowed from that to a consideration of the conceptual map for what was being attempted. Terry suggested that what could be done was to use the model that had been used successfully in developing the Palliative Care Program and they discussed other programs for possible inclusion. Winifred commented that it was more important for the document to be understandable than "academically pure."

"We can focus on the client," concluded Winifred. "That's where we can meet together and talk about the patients," agreed Patrick. "Are you meeting with Marwell?" Beryl asked of Terry. "If they are going to join us we've got a lot of work to do."

Donald expressed concern at the prospect of having Marwell Hospital join the group, but Patrick said he was less concerned, although he did see problems in taking the town of Marwell out of the Marwell Health Unit area. "Should we include Marwell in the managers' meeting if they're interested?" asked Beryl. Donald's reply was, "We shouldn't wait for Marwell. If they join, so be it." Terry said, "They have to decide if they want to participate. I'm not comfortable with getting too big, but we'd be fighting our philosophy if we stopped them. They would have to make a pitch and the group would have to decide whether to take them."

Marwell and Timberwell Hospital Board Representatives Meet

The meeting between the representatives from the administrations and boards of Timberwell and Marwell hospitals took place in the Timberwell Hospital business office. From Marwell Hospital were the Chief Executive Officer, Darren Eardsley, the Director of Nursing, and the Board Chairman and two of the Trustees. Terry, Bobby, and Rob King, the Board Chairman, attended from Timberwell Hospital. Terry explained that Timberwell and Eaton hospitals had similar funding problems, and for that reason the Eaton hospital did not want to serve purely long-term patients. In referring to the health campus concept, Terry stated that Eaton and Timberwell had populations with similar needs but added, "If anyone wants to get on board, they're welcome. But our advice is not to look at beds. Our focus is on the health campus, which includes preventative health care. We've nailed that down with Eaton, in terms of program services and patient needs."

"It means developing viable programs," Terry said. "We need to focus on programs, not buildings. The buildings should be regarded as no more than inventory. This is a little ahead of time, but we're going to have to go in with good proposals. Rural hospitals should put pressure on the big city hospitals, but it is what happens in [in the major cities of the province] that really counts."

"What is important is for us to work together. We didn't chase Eaton," Terry went on. "They came to us. Now it's up to you . My emphasis is on a strong approach for the good of the community. Others should be doing the same. We want to do it ourselves, and if others want to be part of it they are welcome. The Minister will be interested."

"We'll share our strategic plan. It's no secret. We'll share. If we don't have a sharing and trusting mode we won't survive. It's a matter of getting people comfortable with what's going on."

The meeting concluded with no indication as to whether of not the Marwell representatives were interested in becoming part of the Timberwell/Eaton planning group.

The Proposal Document is Shared

Soon after the meeting Terry sent a copy of the group's proposal to Marwell Hospital, at the request of Darren Eardsly, Marwell Hospital's CEO. Terry told Donald, "I'm after a meeting with Peter Goldthorn, the Chairman of the La Fontaine Health Planning Group, to get some feedback. . . . Let's keep sharing the document so we can get more input. I want the Amalgamated Hospitals Group to get behind us and support us on this. . . . We can share it with the Princess Elizabeth [Hospital] and we can share it with Goldthorn. . . . I'll tell John Holt [CEO of the Amalgamated Hospitals Group] that I'm meeting with Goldthorn."

Later that day Dr Baldwin, the Medical Officer of Health (MOH) from the Marwell Health Unit, telephoned and asked for a copy of their planning proposal. Terry immediately telephoned Patrick. He said that he thought they should meet with John Holt. He also told Dr. Smith of the telephone call from Dr. Baldwin. "Neville asked if we would share our paper with him. What do you think?" He also mentioned the steps they would take next that he had discussed with Donald. "Peter Goldthorn should be invited," Terry said. "He wants to ask me about what I think about La Fontaine. I'll talk about our vision."

Terry seeks an important ally. That afternoon Terry met with John Holt, CEO of the Amalgamated Hospitals Group, at La Fontaine General Hospital and described the health network that was evolving in the Timberwell/Eaton area. "Our vision is a partnership with the city [of La Fontaine]. . . . [Our hospital has] intimidated others because of our population and our large number of doctors," Terry said.

"We've gone with Eaton, the Timberwell Health Unit, and the Timberwell Nursing Home. We'll divide up our services. . . . You may want to add yourself. Timberwell Hospital needs Eaton Hospital's space to rotate our long-term patients. The long-term patients are killing our funding. We'll have to give something up. We are approaching this with the concept of a community health campus."

Terry described he interactions that members of his group had had with Marwell Hospital and with Dr. Baldwin from the Marwell Health Unit. They discussed the difficulties that they were experiencing working with the physicians, particularly at Eaton, and the two spoke of the desirability of establishing an alliance between the Amalgamated Hospitals Group and the Eaton/Timberwell health network, that they had named the Pioneer Country Health Network.

The Timberwell Hospital Board Executive accepts the document. That evening Terry and Donald met with the Timberwell Hospital Board Executive. Terry began the meeting with a preamble, describing how they needed to get support from other parties inside and outside the network. Donald related the progress to date. In the process of discussion Donald re-iterated Terry's vision of partnership between the facilities and Terry stressed the concept of a partnership with the Princess Elizabeth Hospital, the nearest member of the Amalgamated Hospitals Group. The Board Executive accepted the proposal, with only minor amendments.

The following morning, Thursday, September 3rd, at a meeting between the two in Terry's office, Terry told Patrick about the meeting he had had with John Holt. Patrick was most encouraged by John's attitude to forming a partnership between the city hospitals and the Pioneer Country Health Network, and suggested that they add "other providers" to the list of participants in the various programs. Patrick said that he had been contacted by Neville Baldwin. "Neville gave me hell for participating in this network," said Patrick. "He accused me of selling out. Marwell [Hospital] scares him." Terry replied, "I don't think [Marwell Hospital's administrators] are interested."

Pressure on Dr. Smith increases. The conversation focussed on Dr. Baldwin. "Don't let them set you up," said Terry. Patrick said, "I said to Neville [Baldwin] that he should sit down and talk. I want it small so we can sort out our services first."

From that point the two discussed the issue of long-term care and addressed the potentially conflicting needs of Timberwell Nursing Home and Eaton Hospital in that regard. Terry said, "If we do a good job of providing for the long-term patient needs no one can touch us. If we can work this out we can get rewarded." He then went on to describe the vision for the creation of a health campus for the region. Patrick left soon after.

That same day Darren Eardsly called and told Terry that he was negotiating with a hospital near to Marwell with regard to them forming their own planning network using the Timberwell/Marwell model. Darren also wanted to talk about a call he had received from Neville Baldwin. "He is scared we're going to squeeze the health unit administration out," Terry told Darren. "We need to cooperate more and include people like the Community Support Department. And we need to protect our staff, we should only reduce staff by attrition." Terry telephoned Patrick and they discussed the telephone contacts that Dr. Baldwin had been making. It was evident that Dr. Baldwin was placing Dr. Smith under a large amount of pressure.

Later that day Donald, Bobby, and Terry discussed the day's phone calls and the prospects for that evening's meeting between representatives from the boards of the four participating health agencies. Donald expressed concern that the trustees might become bogged down on detail and lose sight of the major thrust. They also expressed concern about not knowing what to expect from the October 6th meeting. "Anything can happen," Terry said, "I'm curious as to how it will work out. I want to be able to sell this [to the various boards]. To sell the vision. If we are better organized we could save a lot of money."

Donald leaves the planning team. The issue of the hospital being underfunded was discussed, and ways that the physicians could be enlisted in support of improving the patient charting and other matters that were central to improving the funding situation. "We can do better," said Terry. "I'll step back from planning," said Donald. In response, Terry said, "I'll bring Patrick in more. We'll make some changes, but we want to sell the idea [of the health network]. We want to build a good continuum of care, to share services, to save money. In terms of the Health Unit, I'm not sure how I see it. We've got Dr. Smith on side, now we should work with the inter-agency group. We also need to get a network board. I'd like to see them talk about that tonight. . . . It'll save money." As he left the meeting Donald seemed unhappy and it appeared that he had felt that he had been obliged by Terry to withdraw from the planning role.

That evening the members of the Executive Planning Committee were in attendance at the meeting at which the agreement to the proposal document was given by the representatives of each of the boards involved. Rob King, Chairman of the Timberwell Hospital Board, chaired the meeting. Donald went through the proposal paper, page by page, explaining the thinking behind the text as he went. In his presentation Donald emphasized the partnership concept on which the document had been founded.

As an introduction to the pages relating to the health programs Donald said, "This is Dr. Smith's. He should talk to it." Patrick explained the idea of the health programs, saying, "We seem to be unique in this approach. This is its strength." The comments were greeted with nods from the Eaton contingent. In response to Dr. Smith's description of the programs, Dr. Simpson said, "Won't this scare the government? They're trying to save money."

The meeting continued as Dr. Smith explained the intention of the specific health programs laid out on the next two pages of the document. He gave examples of how duplication could be reduced, from his own experience. One of the examples he gave was of the situation where both physicians and public health nurses conducted the hip checks on new babies. This example appeared to make a great deal of sense to Dr. Simpson, who, having had this description, seemed, for the first time, to understand what the health program was to achieve. "Does this mean the program committee would be a multi-disciplinary committee?" he asked. Dr. Smith, Bobby, and Terry all confirmed that this would be the case.

The concept of the network was supported by all of the board members present. With a change of name to Richlands Health Network, the board representatives said that they would take the document, with the minor amendments that had been made, to their respective boards for formal ratification. At the break of the meeting those present broke up into conversation groups. Dr. Simpson spoke with Beryl and Warren. He said afterwards that they asked him to attend the meeting of the Eaton medical staff and explain to them what was proposed with the new region.

The Wedding and the Honeymoon

The week after the acceptance of the proposal document Terry, Bobby, and Warren met with Peter Goldthorn, the Chairman of the La Fontaine Region Planning Committee. Terry opened the meeting by talking to the network proposal. He emphasized the way in which the boards involved were working together, and mentioned that he could envisage a single board being in place in the area within three to four years, and said that it could perhaps include representatives from La Fontaine. This was the first of the main events that occurred following the acceptance of the proposal document by the representatives of the respective boards. The major events following the acceptance of the proposal document are shown in Table 3.

Table 3

Time-Line for the Final Phase of the Richlands Health Network Planning Process

* **September 8** -- Terry meets with Peter Goldthorn, the Chairman of the La Fontaine Region Planning Committee to discuss the proposal for the area planning network.

* **September 14** -- The Minister of Health postpones the regionalization process;

--The study participants resolve to proceed with the area planning network despite the postponement of the regionalization process.

* **September 19** -- The Timberwell Hospital Board formally accepts the proposal document for the area planning network.

* **September 21** -- Terry and Warren meet with Jim Perich, from the Provincial Health Department, who endorses the network proposal with a degree of enthusiasm.

* **October 6** -- Provincial Health Department representatives indicate a desire to work as part of the Richlands Health Network;

-- Dr. Baldwin, from the Marwell Health Unit, refuses an invitation to have that agency become a part of the network;

-- The Executive Planning Committee decides to investigate a number of health programs for possible immediate implementation;

-- Arrangements are made for hospital department heads from Eaton Hospital and Timberwell Hospital to meet and discuss methods of rationalizing support services.

* **October 9** -- In response to staff concerns about job security the proposed meeting of hospital department heads is cancelled.

* **October 12** -- The Executive Planning Committee meets to discuss problems associated with implementing the rationalization of support services and it is agreed that a five-year implementation plan for the network should be developed.

* **November 6** -- Reports on proposed health programs are presented by members of the Executive Planning Committee and sub-committees to implement specific health programs are agreed upon;

-- Patrick and Terry agree in principle to replace the newly-resigned directors of finance from the Timberwell Hospital and the Timberwell Health Unit with one individual who will manage the finances of the two agencies. Patrick and Terry also agree that the Timberwell Health Unit would use the Timberwell Hospital's computer hardware and computerized accounting system.

During the meeting with Peter Goldthorn, Terry said, "We'd go ahead without the Minister. We've got a good plan. . . . We will include all those who want to be in. We can make changes right up until the last day. We are a partnership, and we can take better care of patients because we are small. We're close." In response to these comments, Mr. Goldthorn responded, "It's TQM for the lot. It's empowerment." Mr. Goldthorn asked if his group could refer to the Richlands proposal document. "Yes," said Terry. "We said, 'Let's create a vision.' Our system is a valuable addition."

A few days after the visit from Peter Goldthorn, Bobby, Warren, Beryl, and Patrick attended a meeting of the Eastern Region Planning Committee, at Loon Lake Hospital. Events at the conference illustrated the degree to which the health network planning group had developed into an effective team.

The group's teamwork comes to the fore. The conference had been called to discuss the possibility of establishing a health region, but with the exception of the Timberwell/Eaton group no effective steps towards the creation of regions had been taken. With no reports to receive, the chairman said that he had heard that something was happening in the Timberwell area and asked Warren to talk about it. He did so, and was supported in what he had to say by Patrick, who spoke at length about the district-wide program approach that they were planning to implement. Bobby supported the comments of the other two by clarifying how the four facilities were working together as partners. Terry was not in attendance, as he was involved in another conference.

After this episode the group members reported a high degree of satisfaction with the meeting and were encouraged that their group was working in unison towards a goal that they all understood and agreed upon. Their ideas had been criticized by many at the meeting and they sensed that those that were critical did not seem to understand what the Minister of Health or their group were trying to achieve. That their group was not only able to understand the Minister of Health's intentions but was able to collaborate in putting them into practice gave the group members a sense of identity and achievement.

Timberwell physicians impress Warren. On Monday, September 14, Warren telephoned Terry with two pieces of information. He advised that Dr. Simpson and Dr. Briggs had visited Eaton and attended a meeting of the medical staff. Warren said that he was most impressed with the presentation that the doctors had made. They had pulled no punches and had told the Eaton physicians "a few home truths." He also advised that he had some amendments to the planning document that he wished to have discussed. He had made the changes and he would FAX the amended copies to Terry and Patrick so that they could consider them for discussion. It seemed that Dr. Baldwin had been in touch with Warren because the changes he had suggested involved the addition of the Marwell Health Unit in the list of members of the Richlands Health Network.

Regionalization is Postponed

Later that day Dr. Smith called to tell Terry that he had received a FAX from the Provincial Board of Health saying that the Minister of Health had postponed the implementation of the regionalization process and the October 6th meeting "was off until further notice." Patrick said that he felt they should continue with developing their network, that the regionalization issue would come again, and that by continuing now they could get ahead of the others. Terry said, "For the survival of health care in this community we should let the government know what we're doing. We've got a solid program. You know how good people are at putting things off."

Later, Patrick came to collect a copy of Warren's FAX. Terry and Patrick were in complete agreement that the Minister of Health's postponement of the program should in no way prevent them from continuing with their network group. Terry asked Patrick if he was surprized at Warren wanting to include the Marwell Health Unit. Patrick said no, he wasn't, and that they should be include it for the moment. He then suggested that they add another page, if everyone agreed, that he had brought with him. "This includes the three levels [of Board, CEOs, and program implementers]."

We'll go ahead anyway! Patrick said, "Now that October 6th is off we have time to slow down a formal presentation. We just got this working. . . . I don't think we've got Marwell [Health Unit] too close to the top [of our priorities]. . . It's just if it's at Eaton they'll do the work. I don't want to see three medical officers of health fighting over some border issue. . . . I think we've got everything we need [to implement our plans]. We should just pick a [health] program and do it. Pick an easy one and get it done . . . by December," Patrick continued.

The following week, September 19, Terry and Donald were discussing the preparation for the Timberwell Hospital Board meeting that night. "Circulate the [Minister of Health's] letter," said Terry. "We'll push for the approval of [our] plan, not verbatim but in principle. We'll push for administrative moves, to form a merger. No. A partnership. Jim Perich [a Provincial Health official who was involved with the administration of the Timberwell area] is coming down next week," said Terry. "I'm going to be tough and say that we're doing things anyways."

A meeting of the Timberwell Hospital Senior Management Group was held later that day. Terry told the meeting of Jim Perich's visit. "It's risky but it has to be done. If we can come up with something the government can't take things from us. We're working together, sharing, and the boards are willing to consolidate the leadership. This is threatening for administrations but it has to be done. We want to continue. We have the opportunity to do something worthwhile, and we have momentum."

"We should have everything down for when the new board comes," said Dr. Simpson. "We had a good meeting with Eaton. We didn't know what each other were doing. There is lots we can do together. We've invited them to our next meeting. But the problem people weren't there."

"So tonight is to get this document approved," said Terry. "We set a time to get it on board. Perich is coming to see me, Malcolm would you like to meet with him? We can get things going. We have a glorious opportunity to move ahead and get going."

The Timberwell Hospital Board Gives Formal Approval

When the issue of the health network came up at the Hospital Board meeting that evening Terry began by addressing the membership of the network. He said there was room for a lot more. "That list will grow as time goes on," he said. "The map will change as time goes on. It's a partnership and that will mean that we will make some bad decisions. It's not a full merger at this stage but as time goes by merging will be inevitable. . . . [the Minister of Health] wants to see innovation and we can save money. . . . Amalgamated Hospitals want to sit in. We've put in 'partnership' a lot and we don't see this as a status quo organization or a status quo program. . . . We've made a commitment administratively to go ahead. Not to do so would be a mistake." The Board accepted the document, allowing the network-creation process to proceed.

A Provincial Health Official Buys the Package

The meeting with Jim Perich, the Provincial Health Department official responsible for the Timberwell/Eaton area, visited Terry and Warren at Timberwell Hospital. Terry went through the document, explaining and clarifying the ideas and the basis for them as he went. He explained that the Palliative Care Program could be used as a model and in some cases basic services could be taken from the city. Terry continued through the document, explaining a number of proposed programs and mentioning Dr. Smith on a number of occasions. He also mentioned examples of duplication of services that were currently occurring.

"It's amazing, looking at this," said Jim. "There's all this concern with boundaries and mandates etc. I said we should focus on health needs at a meeting last week. You've done a variation on that. Our preoccupation with committees have increased. There are turf battles."

"That's why we started this," replied Terry. "One of us said let's look at services and programs, not boundaries. The Princess Elizabeth has a copy and Amalgamated Hospitals have a copy, but it will still take a long time to happen. If we can make it happen the others will want to catch up. . . . We don't want to be territorial. If we can make this work, who cares? It can mean that we keep the specialized services. We haven't added costs, we're working together."

"So that's our approach," he said. "This can be made to work. It has potential and it depends on our ability to work together. . . . And what does this lead to? A health campus! Constructed in such a way that there is no increase in cost. Imagine! There could even be a reduction in cost!"

Jim said that he thought the document was very impressive and asked if he could pass it around. Terry's answer was, "To everyone! The more that do this the more likely it will work." Jim wanted to know whether the hospitals in La Fontaine had seen the document and Terry told him about the visit by Peter Goldthorn.

"What I like about this approach," said Jim, "is that it requires people to think provincially. The approach is based on health needs, not organizational needs." Terry responded, "You should invite people like us to talk to your bosses."

"The Minister's letter hasn't meant a damned thing to us," continued Terry. "Our boards are looking at the formation of one board. The Minister's letter actually bought us some time." Jim thanked Warren and Terry for inviting him out and talking about their proposal. The meeting ended and Terry showed Jim out.

When Terry returned to his office he and Warren discussed the meeting. "We made a good sale today!" Terry said. "It's a sunny day! He's going back with a plan in his pocket. His bosses will get it tomorrow. He's picked up our focus. We'll have to get together to see how we'll make the sale. They won't give us money but they'll trust us. They're being stabbed in the back but they have to save money. We should concentrate on the document at the next meeting. I think we should form sub-groups to support the services coordination. It's time to get the staff involved, not just you and I."

Terry promotes the network. Between that date and October 6 Terry continued to talk to everyone he could about the network. He addressed a meeting of department heads at Timberwell Hospital, telling them that the programs and services for the network would be "nailed down" and that they would be involved. Terry was chairperson of the Inter-Agency Group, comprised of a number of agencies directly and indirectly involved in health issues, and he used meetings such as those to promote the health network concept.

Finalizing Plans

On October 6 the Richlands Health Network Executive Planning Committee met in the Eaton Hospital Boardroom. The meeting was attended by two managers from the Eaton Hospital and three representatives from Provincial Mental Health Services were also in attendance. Dr. Baldwin had been sent an agenda and was invited but did not attend.

Warren began the meeting, saying that despite the Minister's postponement of the October 6 meeting the group had decided to continue. "We'll go ahead," he said.

"This should have happened a long time ago." He explained why Dr. Baldwin had been invited and described the meeting that he and Terry had had with Jim Perich. "He left quite exhilarated," said Warren. "He was quite impressed and said he would share our document with others. Terry has discussed the document with Doug Cosgrove, the Assistant Minister. He had no problem regarding our relatively small size."

Each of the members of the group had been contacted by Dr. Baldwin. He wanted nothing to do with them, and was particularly critical of Dr. Smith for being involved. The Mental Health representatives said that they were in agreement with what the group was trying to achieve. Consideration was given to including Mental Health Services' activities as a part of the Health Care Program. "We should really write those services into the overview," suggested Patrick, and Terry added, "We're looking at services, not boundaries."

"We decided not to look at boundaries. Let's concentrate on what we can do for the communities," said Warren. "We will meet after this to look at sharing services between the hospitals. We need an inventory of services to see where you can fit."

There was general discussion on the possible working of the network. The members were concerned that Dr. Baldwin's opposition to the formation of the network could make it's functioning difficult, particularly in Eaton, which fell within the boundary of Dr. Baldwin's health unit.

Patrick had proposed that an extra page for the network documentation, containing a structural diagram or the health network. He explained how they would function. "In my research for my Masters thesis I found there was a need for three levels [in an organization like this]. In effect that is what's happening," he said, and went on to talk about the leadership in the organization. "The leadership has been shared," he said. "This is leadership without bosses. There are no bosses. It's shared leadership."

"We don't have one leader," added Warren. "That's been our practice all along. Not one leader. We move meetings and we move chairs."

The meeting moved on to discuss more specific issues relating to which programs they might establish first. The Mental Health representatives agreed to provide an inventory of the services that they provided and after lengthy discussion the format of the next meeting was agreed upon.

The meeting adjourned and the Mental Health Services people left. The others all remained to discuss the ways in which they might share support services.

Firming up decisions on support-service sharing. With the Mental Health Services people having gone, the group met as the Management Planning Committee. The meeting began with a discussion on financial management. The Health Unit's Finance Director had announced his resignation and it was agreed that they were presented with an opportunity to use attrition to share services, particularly as the Eaton Hospital Finance Director was going on maternity leave and the Timberwell Hospital Finance Director seemed likely to be leaving for a better job.

A number of other possibilities, including Materials Management, Maintenance, and the Central Sterilizing Room were discussed and it was agreed that the department supervisors from the two hospitals would meet the following week to discuss ways in which they might work together.

Concerns are expressed. The matter of this meeting was discussed at the Senior Management Group meeting at Timberwell Hospital the following day. Bobby said that the staff at the hospital were worried about their positions. Rumours of job cuts abounded and the feeling was that they should hold off on the creation of the network because the government had said to wait. The unionized departments could be most difficult to deal with. The departments with which Vincent worked seemed to be the ones that were most concerned and he argued that things should be slowed down.

"They may have to travel to keep their jobs," Terry said, "but they are saying, 'Why do we have to change?'"

Settling Down to the Post-Honeymoon Marriage

On the Friday after the the meeting at Eaton Hospital Bobby and Beryl attended a meeting of Directors of Nursing and they discussed the sharing of services between the two hospitals. They became concerned as it appeared that the hospital staffs were not aware of what they were supposed to do as they had been given no guidelines within which to work. There appeared among some of the staff at the Eaton Hospital, which had a relatively large number of employees in some departments, the understanding that they would take over the functions of the Timberwell staff. The Timberwell staff felt that they were being asked to meet and decide how they were going to abolish their own jobs. "We need a vision of where we'll be in five years," said Bobby.

The two agreed that the meeting between the department supervisors of the two hospitals, which had been planned for the following Thursday should be postponed, and that the Executive Planning Group should meet to discuss the situation. Bobby and Beryl agreed that they would suggest this to Terry and Warren.

Sharing Support Services is Reconsidered.

The following Monday Bobby met with Terry and Beryl with Warren. They agreed that the Thursday meeting between the department supervisors be cancelled, and that the Executive Planning Committee meet instead.

The meeting was held on October 15, at Eaton Hospital. Warren, as host administrator, chaired the meeting, which was attended by Terry, Bobby, Beryl, Vincent, Winifred, and two department managers from Eaton Hospital.

Lengthy discussions occurred as to what to do and it was agreed that the group would meet again on November 13 and put together a five-year plan. They felt that if they could establish their goals that the staffs of the hospitals would be able to plan without feeling so threatened. With these arrangements there was a general feeling of relief that the problems had been addressed. All felt that the meeting had been very gainful.

Planning is Completed

On Friday, November 6 a meeting of the Executive Planning Committee was held. Attending were Terry, Patrick, Winifred, Beryl, Warren, and Bob Kingsley (from Mental Health Services). Bobby was on holiday. The meeting involved Terry presenting a report on Palliative Care, Patrick presenting a report on Teen Health, and Winifred presenting a report on Long-Term Care. Terry presented documentation of the way in which the Palliative Care Program had been established, with a view that it be used as a model for other programs.

Throughout the meeting Patrick made use of the white board, drawing an organizational diagram showing where the different programs fitted into the conceptual map of the organization. Winifred questioned the need for the diagram.

Patrick replied, "We want to keep the structure so that if we want to say what we're doing we can show it. Just be aware of the concept. They might fund our network." He said it was important to show that it was part of the network. "[We could receive funding] if it's viewed as part of our health network structure, not the inter-agency group. Can I propose that it's important for us to show what we've accomplished. Can we take the step of saying we've formed the Health Care Program Group and the Palliative Care Group? I'll form a School Program and a Teen Program."

They discussed and agreed on the agenda for their next meeting. At the end of the meeting Patrick said, "This has been easy so far. When we get to dividing up the savings it won't be so easy." They agreed that the Support Services Committee would meet on December 15th. The Executive Planning Committee would meet on January 8th.

Conclusion

With the decision to form the program committees whose brief it was to implement the chosen programs, the November 6 meeting marked the end of the planning period. The implementation of sharing support services had begun some time before with staff from the Medical Records Department from each of the hospitals visiting each other to share knowledge and expertise and the possibility of one hospital using staff from the other during busy periods. The Palliative Care Program had been active for more than a year and as a program that pre-dated the formal plans for the network had functioned as a working model of a health program. A further example of cooperation between facilities on health programs between the facilities had occurred when Bobby went with Beryl to La Fontaine General Hospital to address the feasibility and desirability of Eaton Hospital re-establishing a day-surgery program. In their discussion the issue of duplication of service between the two hospitals was a major consideration.

Further sharing of support services was arranged on the afternoon after the November 6 meeting with Patrick and Terry meeting with Vincent and a member of the financial staff from the Health Unit to look at the Timberwell Hospital's financial package. They agreed that the Health Unit would share the use of the hospital's financial system and within a few weeks they formally agreed that the two agencies would use the same Director of Finance.

Shortly afterwards Terry began work with a manager from the Eaton Hospital on preparing a feasibility study of ways that the two hospitals could share support services. In a period of a little less that five months, the health network had been planned and the implementation process appeared to be gaining momentum.

CHAPTER FIVE

The Health Network: Machine or Organism?

Introduction

The Richlands Health Network comprised four facilities, with a Provincial Government Department that showed interest in joining late in the case study period. The experiences of the participants in the organizations from which they came were important in both the way that they regarded the Minister of Health's directive on the regionalization of health and the way that they regarded the creation of their own health network.

The differing world views of the participants became evident as the study proceeded and the different assumptions and beliefs often appeared to be in competition. Through the analysis of the data a number of apparently competing themes such as "Participative Management" and "Cooperation and Trust" emerged at the same time as those of "Hierarchical Thinking" and "Boundaries and Territorialism." The conceptual framework used for the study helped in developing an understanding of these apparent contradictions.

The framework conceptualizes leadership as having three components--semantics, syntax, and phonetics. This chapter traces the participants' essential understandings--the meanings that comprise the semantics of leadership--through an analysis of the data. To understand the semantics of leadership is to understand the meanings and values to be conveyed (Pondy, 1978, p. 89).

For some of the participants membership of an organization meant being in a bureaucratic structure where people's behaviour was governed by policies and regulations and there was control through a hierarchical relationship between members.

In this conception leadership and position held similar meanings and organizations were considered to be static and predictable, rather like machines.

Other participants, however, believed that organizations needed to be flexible and the relationships between people were important. Terry believed that the "old fashioned" ways of thinking about and managing organizations were no longer able to cope with the demands placed upon organizations. Management had to be more consultative and more collaborative. To this way of thinking, membership of an organization was dependent on relationships between people, not based on hierarchies and positions. Such a relationship required collaboration between organizational members that would allow the organization to respond to ever-changing demands, in an organic fashion.

Leadership, in this understanding, meant something different to position. Terry's understanding was illustrated when, in an interview early in the study, he was asked who the important leaders in the hospital were. He replied, "Oh, there are about 137 of them."

Various participants in the study had thus attached differing meanings to their organizations and the part that leadership played in them. The organization-as-machine metaphor suggests how the conceptualizations that the participants may have had of their own organizations and organizations in general may have affected their actions in the creation of the health network.

The need for flexibility and responsiveness to change that the second of the two conceptions of leadership referred to above would demand raised the conception of organizations as organisms rather than as machines. Some of the competing themes that emerged from the data can be understood if the organizations are considered in terms of being organic. The themes of "Sharing and Trust," "Boundaries and Territorialism," and "Survival" can be understood in those terms. In addition, the them of "Group Culture" suggests that the organization evolved is an organic, living thing.

The organization-as-organism metaphor allows additional understanding of the process through which the network came to be.

The conceptual framework, "leadership as language," assists in understanding how these issues relate to leadership. The organization-as-machine metaphor addresses the meanings and values placed upon organizations by some of the participants. How these meanings emerged from the data is explored below.

The Organizations as Machines

Using the metaphor of the network as a machine, the structure of the health network that was formed is explainable in terms of the participants' personal and organizational experiences. Morgan (1991) comments that

> organizations that are designed and operated as though they were machines are now usually called bureaucracies. . . . We talk of organizations as if they were machines, and as a consequence we tend to expect them to operate as machines: in a routinized, efficient, reliable, and predictable way. (p. 22)

The agencies that joined together to form the Richlands Health Network can be regarded as machines, as described above. The requirements of bureaucracies are described by Morgan (1991, pp. 24-25) as emphasizing "precision, speed, clarity, regularity, reliability, and efficiency achieved through the creation of a fixed division of tasks, hierarchical supervision, and detailed rules and regulations." These are clearly applicable to the organizations that appear in this case. Handy (1978) describes bureaucracies as role cultures, and notes that

> monopolies, including the civil service, state industries, and local government can reasonably assume predictability too, since there is no competition around to disturb their vision of the future. . . . [Such organizations] are efficient when life is predictable. They will usually respond to a changing environment by ignoring it . . . . Role cultures respond to drastic changes in the environment (changing consumer preferences, new technologies, new funding sources) by setting up a lot of cross-functional liaison groups in an attempt to hold the structure together. (p. 31)

Both of these responses occurred in the study.

With the exception of the Eaton/Timberwell group, the Eastern Region Planning Committee (and most of the health facilities in Western Province) chose the former response and ignored the Minister of Health's call for the creation of regions. The facilities in the town of Eaton and the district of Timberwell chose the latter response.

The difference between the attitudes and actions of the two groups may well have been a reflection of the groups' organizational goals. Using the organization-as-machine metaphor, Bolman & Deal (1991) describe the link between structure and goals stating, "Embedded in an organization's strategy are its goals. From the structural perspective, organizations are created almost exclusively to accomplish goals" (p. 73).

In Western Province, acute-care hospital funding methodology encouraged hospitals to provide efficient patient treatment as measured by hospitalization times. Hospitals tended to develop the goal of accurately recording the physicians' diagnoses and concentrating on achieving early patient discharge relative to the degree of illness or injury. This structural feature became evident in the stresses between the physicians and the administrators in the case. Bolman & Deal (1991, pp. 66-67) explain these stresses in the following way:

> Hospitals . . . have two official structures, each with a different design. One is a more traditional hierarchy of authority that controls and coordinates the work of relatively unskilled people such as receptionists, custodians, food service workers, record clerks, and secretaries. At the apex of this hierarchy is the hospital administrator, who is responsible for non-medical operations. The other is the collegial structure, governed primarily by professionals. A medical director (M. D.), along with various committees of physicians, oversees and coordinates medical care. A director of nursing (a professionally trained nurse) supervises and makes decisions about how nurses provide care. Tension between these administrative and collegial structures is a regular part of day-to-day relationships in hospitals.

The funding mechanism for hospitals that had been in practice for only a short time had created the need for cooperation between the physicians and the administrators. When the Minister of Health's policy of regionalization was announced, however, it placed a different and new set of demands on health facilities.

The responses that the participants had to the directive for the creation of health regions can be explained in terms of their conceptions of their organizations, described by Bolman & Deal (1991) as "mental maps." These mental maps "influence heavily what we see and how we interpret the world around us. . . . What you believe can determine what you see and what you get" (p. 33).

Few health networks were formed in response to the Minister of Health's regionalization initiative, which may have been a reflection of the unsuitability of the bureaucratic structures of the majority of the health service organizations to cope with change.

The Machines of the Richlands Health Network

The Richlands Health Network was created from four different facilities: two acute-care hospitals, a nursing home whose brief was long-term care, and a health unit whose employees worked largely at the prevention of health problems. The differences between the agencies and the conceptions of their administrators presented a number of challenges that had to be overcome in order that the network could be created. An understanding of the events of the case is enhanced when the meanings participants made of their organizations, and the consequences flowing from them are addressed.

Patrick, Warren, Beryl, and Winifred conceived the Timberwell Health Unit, Eaton Hospital and the Timberwell Nursing Home as having similar structures. The data suggested that Patrick, Warren, and Winifred conceived of their organizations as bureaucracies with a hierarchy of positions and consisting of a number of departments that operated separately. As chief executives these people were expected to lead their organizations and be responsible to their respective boards for the operation of their facilities. Such organizations are described by Handy (1978) as Greek Temples.

The Timberwell Health Unit. Patrick agreed that the the Timberwell Health Unit resembled the Greek Temple shown in Figure 4. This structure is considered to fall into the category of organization-as-machine because it is both static and predictable. As described by Handy (1978), the system was "held together by a whole set of rules and procedures (call them manuals, budgets, information systems or what you will)" (p. 29).

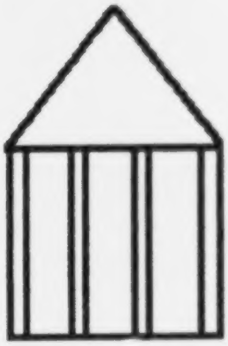

Figure 4: The Greek Temple
From *Gods of management* (p. 29) by C. Handy, 1978, London, Souvenir Press.

The manner in which Patrick conceived the departments in the Timberwell Health Unit as operating separately from one another was illustrated by his decision to locate departments in different locations within the Health Unit district. This was done so that the people in the departments would be closer to the people for whom they provided their services.

While agreeing that the Greek Temple was an accurate description of a health unit, Patrick did not see that structure as being inviolate. He considered the provision of health services to be the prime reason for the existence of health units and and he was prepared to change the structure of his organization if the delivery of such services would be improved. This reasoning was the basis of Patrick's vision of a health network focused on health programs rather than on the agencies. His willingness to change was the source of the criticism that Patrick received from other Medical Officers of Health during the course of the study. They did not want to see the structure of health units change.

All of the facilities in the case had their procedures regulated by manuals, budgets, and the like, they differed in the degree to which physicians were involved in their organizations. Patrick Smith was the only physician working in the Timberwell Health Unit. The existence of the physicians was where the health unit differed in structure from the Timberwell Nursing Home and the Eaton Hospital.

Eaton Hospital and the Timberwell Nursing Home. Physicians could apply for privileges at Timberwell Health Unit or Eaton Hospital, which gave them the right to admit patients and to use resources of the facilities. The Medical Director, who was a physician, was part of both the hospital's administration and the physicians' professional group.

Warren and Beryl both agreed that this model was a very good description of their hospital. In an earlier draft of this chapter, the Timberwell Nursing Home was included in the preceding section with the Timberwell Health Unit, however, when it was discussed with Winifred she said that the Nursing Home was like Eaton Hospital in structure because the physicians fitted in the same way. A representation of the organizational structure of the Eaton Hospital and the Timberwell Nursing Home is illustrated in Figure 5.

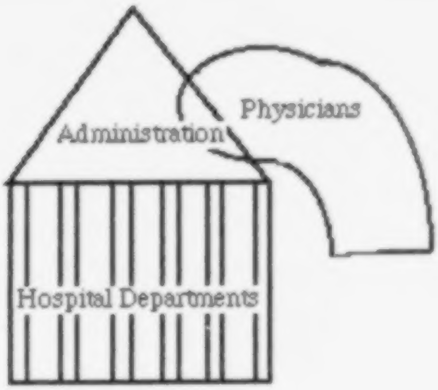

Figure 5: Eaton Hospital and Timberwell Nursing Home: Modified Greek Temples.

Such a conceptualization had some important implications for the creation of the health network. The Greek Temple model makes explicit hierarchical relationships and leadership is considered to come "from the top." An analysis of the data shows that Patrick and Winifred were the only ones from their organizations that were involved in the planning of the network, an illustration that they saw themselves being the direction-setters for their organizations.

Patrick described the involvement of others from his organization in the planning network as impossible because they did not have time for anything other than their own jobs. Warren initially attended meetings on his own and Beryl did not attend any meetings until August 13 when she represented him while he was on holiday. Other managers from Eaton Hospital attended the meetings on October 6 and October 12. The involvement of these people towards the end of the study, and the increased involvement of Beryl as time passed were indications that Warren's association of leadership with position was becoming less focused.

A further consequence of regarding the facilities as Greek Temples was the way in which the concept was sympathetic to the existence of the boundaries that each facility had to define its district. The image is suggested of each of these facilities as a Greek Temple on the top of a hill and surrounded by a fence to keep outsiders away. If a meaningful relationship of cooperation between the organizations was to develop which would allow a health planning network to develop, these conceptions of the organizations would have to be modified.

Under the leadership of Terry, Bobby, Vincent, and Donald the organizational structure of the Timberwell Hospital had been evolving from the bureaucratic model described above for a number of years and a collaborative relationship between the senior managers had developed.

Timberwell Hospital. The Timberwell Hospital's Administrative Manual contained an organizational structure which was of classical bureaucratic form. Terry Neville, the Chief Executive Officer of Timberwell Hospital, was attempting to establish a more participative management structure. In an interview at the beginning of the study Terry addressed the issue of organizational structure and the way in which the leadership in the hospital functioned. In doing so he drew a diagram of the hospital's organizational structure, shown in Figure 6. With regard to the diagram, Terry said,

> This is a conceptual framework because I don't create an organizational structure diagram until it reflects what the organization is. It's not written down until the organization shifts. We (the 14 Department Heads) get together about once a year in a serene environment and work on it. I would like to involve everyone, but its difficult to do. But I will involve everyone when everyone wants to be involved. It's evolutionary. I won't force it down anyone's throat.

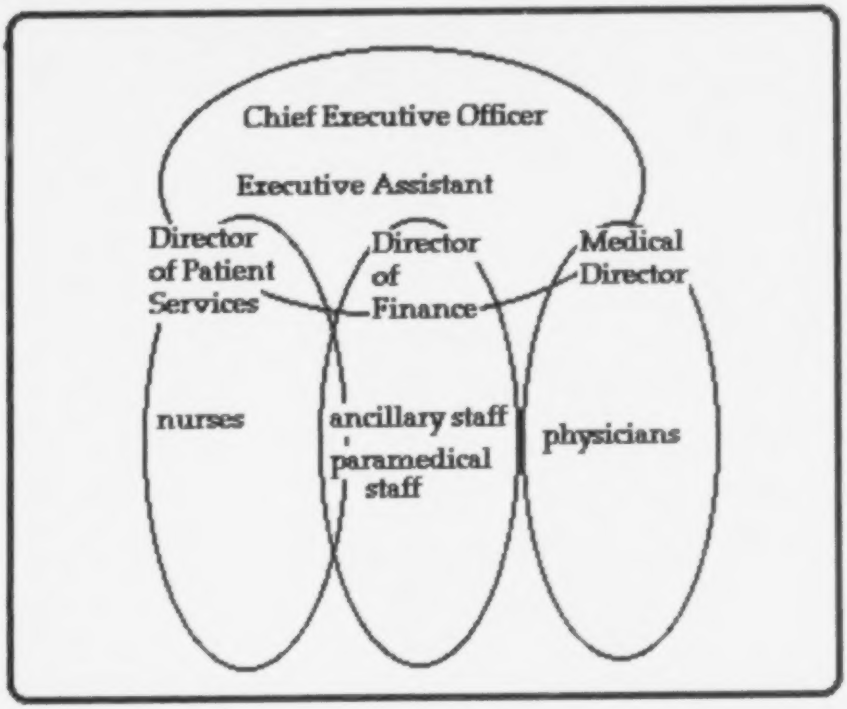
Chief Executive Officer
Executive Assistant
Director of Patient Services
Director of Finance
Medical Director
nurses
ancillary staff
paramedical staff
physicians

Figure 6: The organizational structure of Timberwell Hospital

The groupings in the organization were drawn as elipses to show that they were intended to represent clusters of leaders.

As the case unfolded it could be seen that this aim was not always achieved, but what is important is that the diagram represents what Terry conceived the organization to be, and the Senior Management Group operated in a collegial manner. Bobby Kennedy, the Director of Patient Services, worked closely with Vincent Hampson and Donald Scott, the other members of the Senior Management Group, and was aware of and involved in the process of the creation of the Richlands Health Network. Her behaviour was in sympathy with Terry's conceptual model. Bobby said,

> I've felt very involved. And I think that's different than in some facilities. . . . It's not like that in different facilities where nursing managers have been involved very little, it's only been the board chairman and the CEO. I've been at the meetings and the talking that goes on so I've been lucky. Incredibly involved.

The other directors of the hospital, Vincent Hampson and Malcolm Simpson, did not have the same degree of involvement in the health network planning process, however.

Vincent Hampson, the Finance Director, had been invited by Terry Neville to become an integral part of the regionalization process but his involvement was limited and he attended just one of the Management Planning Committee and that was when the planning for the health network was all but completed. When asked about his involvement prior to that meeting he said, "I think that before that I hadn't been involved that much in it." Vincent did not seem to see involvement in the process as a part of his role.

Terry Neville had been very conscious of involving the Medical Director, Malcolm Simpson, in the regionalization process. Dr. Simpson did not see such administrative issues as the most important to the hospital, however. He said, "The function [of this hospital] is to provide health care." In Dr. Simpson's conception of the hospital's structure, the medical function would be central. He saw the role of the administration as that of supporting the physicians in this central purpose of the hospital but was critical of the administration because there was insufficient focus on health care.

In one interview Dr. Simpson said of the administration, "I don't think the administration has shown the ability to say to itself, 'Well, what does this actually do for health care, for the good of the patient? Probably nothing. If not, let's not do it then.'"

He went on to say that his major role was to help management make sound policy and come up with ideas that would further patient care. "We can then take it back to the medical staff . . . . My other function is to, not regulate, but oversee patient care in the hospital to make sure it's up to current medical standards. To respond to complaints and nursing concerns and management concerns about something that's happened."

The mental map that Dr. Simpson had of the hospital had a clear impact on his view of the regionalization issue. He supported the concept from the beginning because it would make hospital administration more efficient. "Instead of having a pocket here, a board here, and administration here, you're trying to put them together so that you can coordinate things," he said.

If a health network was to be successfully planned and established in the Timberwell/Eaton area the traditional separation of the various agencies had to be ignored. In suggesting the creation of the network based on the hospital and the health unit in Timberwell, applying the concept of a health campus, Terry became a leader by showing the way to the creation of a new order. For the group to be able to work together effectively they needed to develop a common understanding of what they were doing. The manner in which they did this, under Donald's leadership, involved the use of some quite structured methods of organization, which reflected Patrick's, Warren's, and Winifred's understandings of organizations. Donald's highly developed managerial skills and his comments in interviews illustrated that he had a similar view of organizations to them, and he saw organizations as structures as described by Morgan (1991).

The structured approach to the planning of the health network was a reflection of these understandings, but at the same time the collaborative approach that had been the practice within the Senior Management Group at Timberwell Hospital was the medium through which the planning was achieved.

The interactions between the participants and their actions together can be understood as involving the articulation of the meanings and values that they associated with the organizations--the syntax of leadership. Terry constantly articulated the need for sharing and equal partnership and Donald played a leadership role in keeping the process moving forward. To continue the metaphor, it was as though the group was building a machine, but they were doing so in a collaborative manner.

Constructing the Richlands Health Network Machine

Terry, Donald , and Bobby considered that the planning of the health network would be easiest if a time-line was prepared. This can be understood as a construction schedule for the machine. Using the machine metaphor, what was to be attempted was the preparation of an assembly line along which the new model for health care would travel, with parts being added and refinements being made as it travelled along. The assembly line would end on October 6th when the Minister of Health and senior Provincial Health officials would meet to inspect the final product.

Part of the assembly process was expected to involve the unbolting of certain functional parts from the Timberwell Hospital and attaching them to the Eaton Hospital. Eaton Hospital was considered to be in the advantageous position of having plenty of room in which the unbolted sections from the Timberwell Hospital could be placed. Parts that were considered to be possibilities for transfer included the pharmacy, the radiology department, the rehabilitation department, and the laundry. These boxes that represented these departments would be removed from the Timberwell Hospital structural diagram and placed on the Eaton Hospital structural diagram.

Donald Scott was important in the design of the new organization. At the Senior Management Group meeting at the Timberwell Hospital on July 15 Donald prepared the first sketch plan for the model. The plan included the various different components and how they might fit together. At this meeting it was agreed that it would be important to get the various boards to agree on the function of the new organization.

The first formal step in the creation of the new region was on July 24 with a meeting between the chief executives of the four facilities involved. Donald Scott also attended. The minutes of the meeting record that "structural changes will not be implemented until the 1994/95 fiscal year when budgets will be approved on regional basis." In keeping with the machine-like notion of the people in the organizations having clearly defined roles.

Donald continued to play an important role in the planning and design process. Terry had told Donald that they would "take his time from Acute-Care Management:" a cog from one part of the machine was to be transferred to another. At the second planning meeting involving the whole group Patrick indicated his conception of his organization as a machine in stating that he was "more day-to-day" and in so doing presented the concept of a program approach to health care in a diagrammatic form, showing how the pieces could be made to fit together. The organization was conceived to be a machine, comprised numerous interlocking parts, that would function in a routinized way. At this meeting the rudimentary design of the organization that had previously existed was refined.

As the design/construction process continued through July, August and September, the terms used by the participant continued to reflect a mechanical model. At one meeting between Terry and Donald the funding problems that were being encountered at Timberwell Hospital were related to the regionalization process. "The health campus idea would solve all this, if we cooperated with Eaton Hospital and Timberwell, the long-term patients could be taken from our beds and they could become day-use beds," Donald said. The concept of interchangeable parts was repeated.

On September 25 Terry had told the Timberwell Hospital department heads, "We will have to nail the program down, and you'll all be involved." They were "nailed down" on November 6.

At the September 25 meeting there was considerable discussion on the organizational structure. Patrick spent a considerable time creating a diagram of the organization as the meeting proceeded. Patrick's diagram was based on functions. The mechanical aspect of their thinking was illustrated by such comments as, "These program functions fit in here." Patrick said at one point,

> The Health Care Planning Committee (which is us at the moment) will be different people. We have to coordinate. People have to see that it's part of the structure. We have an inter-agency group. It could set rules, to the extent that it's mandatory, it needs to be seen that it's not a free-wheeling independent body.

These comments reflected a number of terms applicable to a machine and were similar to ones that had been made previously, when on more than one occasion it had been pointed out that in creating their network, they did not have to "re-invent the wheel." In addition to these machine-like references to the organization and the activities of the planners during the planning process, other themes emerged from the data. One such theme was Terry's role as salesman who went out promoting and selling their newly developed model, which had similar qualities to a compact car.

The Compact Car--Cheap and Efficient

The activities of the participants in the study in creating the health network were guided by Terry's vision of a health campus. The vision was enunciated in the document *Community Health Campus: Draft* which Terry had written and wich had been accepted in principle by the Timberwell Hospital Board. The document had been distributed widely. Terry had consulted other health-care administrators in the Timberwell area prior to writing the document.

In the vision document, Terry had used machine-like language, describing contemporary health care facility design as an "outdated model" and effectively called for an updated model that would be effective and relatively cheap to run. The healthcare model had to be redesigned because the "centre of gravity shifts." Dr. Simpson applied the idea to the health system in general when in one interview he said, "We can't afford a Cadillac system any more, our costs are just out of control so it gets shoved onto the nurse and gets shoved onto the patients," and in another interview, "I think our problem is that we have a Cadillac system and maybe we have to start driving a Volkswagon."

The health network was designed largely by Donald and Patrick, based upon the vision that developed. The vision required a compact, rather than a luxury car. At the meeting where the first sketch plan was made Donald said they should make it "small and attractive."

Terry the Salesman. The health campus was designed to be a new, cheap, and efficient machine. From the beginning Terry played the role of the salesman. He went out and hawked the model for their health network, but before he did he worked on selling the idea to prospective group members. He used sales terminology, saying he would like to "sell [Dr. Smith] on the partnership idea," and, "The ambulatory model is something that Provincial Health will buy." Repeatedly Terry made conversation and jokes before and during meetings, using the salesman's technique of putting people at ease. After one meeting he commented to Donald that Winifred had been sold the concept. On another occasion he described the network proposal as, "Really a sales document. We have to sell it to government, to give them lots of reasons to approve it. We have a good package."

Terry set out to sell the package to government and he regarded the meeting with Jim Perich from Provincial Health as a sales meeting. After the meeting with Mr. Perich he said, "We made a good sale today!" And he set out to sell the model to others, saying that he would "sell Peter Goldthorn [the Chairman of the La Fontaine Regional Planning Committee] on what the committee recommends."

The salesman role that Terry played during the study period was similar to the one he played as the Chief Executive Officer of the Timberwell Hospital. His role had been more external than internal to the hospital for a number of years. In the role culture that many of the hospital employees conceived the hospital to be, this external emphasis was resented in some quarters. In the understanding that people's behaviour should be determined by a role statement, some hospital employees saw Terry's role as being always at the hospital, "running things." They did not see that his largely external role was appropriate. One employee stated, "Terry is too willing to give up the reins. People get frustrated. . . . There was unhappiness with Terry not being here. Bobby runs the hospital. Terry needs to explain what he does." Another said,

> With regard to Terry and his role in the hospital, most people would like to see him more internal, more involved. I think he enjoys his role in the external and the Board wants him to be involved externally. . . . On the whole people would like to see his leadership more.

To allow him to play a largely external role Terry had set about employing high-quality people to ensure that the hospital functioned effectively without his direct involvement. Said one of the department supervisors,

> [Terry] has the uncanny ability to have strong people around him. Therefore he can leave things alone. He is very external in what he does, working on behalf of the hospital. He doesn't have a lot to do with what is going on.

Terry said that he had been advised to be more external because he was in an organization that was probably the most threatened in the province. "One thing, though," Terry's colleague had said, "you'll never be acknowledged for what you do. People won't have time for that. But it will be a way for the organization to survive."

Organizational survival was a major theme to emerge from the data and survival promotes a vision, not of an inanimate machine, but of an animal; an organism. Morgan (1991, p. 40) notes,

> Under the influence of the machine metaphor, organization theory was locked into a form of engineering preoccupied with relations between goals, structures, and efficiency. . . . Goals, structures, and efficiencies now become subsidiary to problems of survival and other more "biological" concerns.

In similar way to Terry, the other chief executive officers showed concern for the survival or their organizations and showed that the organizations were more than simply machines. The organization-as-organism relates more to the interactionary aspect of the organizations: the articulation of the meanings and values and the way they are translated--the syntax of leadership.

The Organizations as Organisms

The Creation of the Health Network

The Minister of Health's announcement of June 19 created an environment conducive to the development of a health network in the Timberwell area. Other ingredients that provided the "right mix" for the creation of the health network included Terry, who had been proactively seeking to protect the existence of his hospital and who had developed a vision for health care in the Timberwell district--a vision that complemented the Minister of Health vision of regionalized health care.

There existed Patrick, a forward-thinking Medical Officer of Health who was not only new to the district, which made it easier for him to create changes without feeling threatened, but whose Masters degree research had been on the sharing of resources between health facilities. As well as these chief executives there were other people who made significant contributions.

Bobby was a very effective communicator whose vision went outside her own position in her own hospital, Donald held a Master of Health Science Administration degree and was a talented strategic planner and conceptual thinker, and Beryl had created a network of directors of nursing and hospital department supervisors. In addition, there had been a recent history of inter-facility cooperation and four facilities existed whose administration and governors felt could be at risk.

The vision that Terry had was for this inter-facility cooperation to be the basis on which the new organization would develop. He said that the goal should be "to give each institution identity, but to work collaboratively with a central function managed by the CEOs, collectively." The resultant organization would resemble Handy's (1978) Existential or Dionysus Culture. The representation of this organization is reminiscent of a simple cell and is congruent with the metaphor of the organization as an organism. The health network is represented by the boundary of the organism and the member organizations are shown as the organ systems, interacting as co-dependent entities within the network, and is the conception of an organization represented in Figure 7.

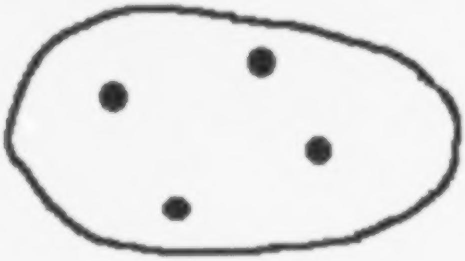

Figure 7: The Existential Culture

From *Gods of management* (p. 38) by C. Handy, 1978, London, Souvenir Press.

The participants in this study agreed that although the ingredients for the cooperation between facilities at the level of a health network had existed for some time, an event such as the Minister of Health's announcement was required to trigger such events.

Feeding the Organism With Money

The Richlands Health Network consisted of interrelated parts and was one of the open systems described by Morgan (1991). Not only did the network as a whole behave in an organic manner, the components behaved like organisms. A major impact on the way the network developed was in response to a major factor in its growth or survival--money. Finance is the food of health care organisms; they need finance to survive and flourish. The two hospitals, the health unit, and the nursing home had been organism-like in the cooperative formation of the network, and in some cases had previously shown an organic adaption to changes in their food source--access to finance.

Timberwell Hospital had responded to a change in funding for acute-care hospitals. During the previous year Provincial Health had changed its method of funding and hospitals were rewarded for decreasing patients' hospitalization time or punished if hospitalization times were considered inordinately long. Furthermore, the funding was made on the basis of a provincial average. Those hospitals that met the provincial average for patients' hospital stay had their funding unaffected, those who did better than the provincial average had their funding increased, and those that did worse than the provincial average had their funding reduced. In effect, the hospitals were made to compete against each other.

The changes meant a significant decrease in Timberwell Hospital's income and when one of the hospital's senior managers left a replacement could not be afforded. The departed manager's responsibilities were shared between Bobby Kennedy and Vincent Hampson. Other than Terry they were the two remaining members of the Senior Management Group. Donald Scott was employed part-time as Acute-Care Funding Manager to guide the hospital in adapting its operations to the new funding arrangements.

The employment of Donald was one example of adaptive, organic behaviour by the facilities. Other themes relating to the organization-as-organism emerged from the data: survival, territorialism, and sharing and partnership.

Survival of the Organisms

Community Health Campus: Draft was the vision document that guided the growth and development of the health network throughout the case study period but the document was not written from a totally altruistic, community-service base. A large part of the purpose of the health campus vision was to aid the survival of the Timberwell Hospital.

Timberwell Hospital was an old building in which, for its size, an enormous number of patients were treated each year. However, the state of the provincial economy meant that the building of a replacement hospital that could better cope with the huge number of patients was not a realistic possibility. The campus idea, if considered viable by the provincial government, presented the opportunity for the construction of a new building. Donald explained the document and the way it was presented by Terry in the following way;

> He sold the idea to the Board as being the most likely way that the government would agree to building a new facility. . . . That approach was the best way to get a new building. Terry took the idea to a senior executive in the Health Department on that basis . . . There was no point in presenting some nebulous ideas regarding improving community health care, without any detail. . . . The health campus idea was presented as the "right button" to push.

The health campus, then, offered a way for the Timberwell hospital to survive and the survival instinct was an important motivator for the hospital employees. The continued existence of the hospital was essential to their own financial situation and cooperation between the health agencies in the area was seen as a way that the survival of each could be maintained. Regionalization and survival were linked by Vincent:

> We have an old building and it gets older and older and you see your capital project get deferred farther and farther and farther. You're this close to the city and there's a hospital twenty minutes away that's a brand new hospital that's not being used at all. If people think about that long enough they think , "Gee, if I was sitting in the government's shoes I know what I would do. I'd try and utilize the hospital that's been built." . . . So I think the common purpose is, at this stage, to survive. And now with regionalization, that's even more evident. We're trying to survive and we're figure sharing . . . services between hospitals is the only way to do it.

The "brand new hospital" was Eaton Hospital. Considerable discussion concerning the sharing of support services between the two hospitals took place during the case-study period. The need for the two hospitals for each other was more basic to their survival than the sharing of support services, however. Their mutual survival related to their medical programs.

As referred to above, Timberwell Hospital had problems with a very high degree of use. Eaton had the opposite problem of significant under-use. From the beginning it was planned that long-term patients would be transferred from Timberwell Hospital to Eaton Hospital, freeing beds at Timberwell and alleviating the bed shortage there while at the same time assisting Eaton by providing them with patients. The long-term patients were referred to by some of the participants from each of the hospitals as "bed blockers." A hospital's patients are its life blood and funding was tied to the services provided to them. The long-term patients had become blood clots for Timberwell Hospital, reducing the blood (patient) flow and the delivery of food (money) to the organism (hospital).

As well as Eaton Hospital being assisted by receiving long-term patients from Timberwell Hospital, the Eaton Hospital Administrator Warren Pritchard was keen to join with the Timberwell facilities for fear of a take over by Marwell Hospital. This third hospital was itself concerned about its own survival, which explained its request for meetings with Eaton Hospital and Timberwell Hospital.

The potential for Marwell Hospital to join with the others was not greeted with enthusiasm by Terry or Beryl. Terry considered that including Marwell Hospital could mean that the Marwell Health Unit would also become involved, and that could mean the network would become too big and unwieldy. Beryl was concerned about Marwell Hospital's financial status. In discussing the possibility of Marwell Hospital joining the health network, she said,

> They have a very large deficit that their board can't cover. . . . So we have our concerns. When we amalgamate these facilities and we have one budget . . . we don't want to be spending a lot of our money picking up someone else's deficit when we we're not sure why they've got it.

To pursue the metaphor of finance as food, Eaton Hospital did not want to be starved because of the overly-large appetite of a fellow network member.

In discussing Marwell Hospital Beryl used language that described the relationship between the two hospitals in quite organic terms. She said,

> I do believe that they had the mother hen impression that we would come running and say, "We're only just a teeny facility please help us." They were surprized that we did have the guts and stamina to do it on our own and Marwell was the one we were not going to do it with.

If Marwell Hospital joined the health network would probably mean that Marwell Health Unit would come with it. The inclusion of the second health unit raised another important theme that emerged from the study--territorialism.

The Marking Out and Competition For Territory

Essential to the process of regionalization was the issue of territory. The requirement of the Minister of Health for different facilities to join together to form regions meant, by definition, the creation of region boundaries. Each of the hospitals had its own hospital district and the creation of the regions meant that each agency seemed to take the position of protecting its own territory as a basic position. The situation was summed up by Beryl when she commented,

> I think the biggest problem right now is the turf. The turf, you know, everybody wants to keep what they have, knowing that we can't keep what we have. I think that as employers we're concerned of not only meeting what the community needs but also, for this facility, to make the right decisions for our employees so that they can keep their jobs.

"Turf" certainly seemed to be an issue from the beginning of the study. At the initial meetings to form the region Timberwell Hospital was excluded. As late as August 18 Marwell Hospital saw a region comprising itself, Eaton Hospital, Big Deer Hospital, and High Valley Hospital as the naturally occurring region and saw no place for Timberwell Hospital.

Terry was not concerned about territory because he could see from the beginning that the Timberwell district had sufficient population to form its own region. It was on that basis that he suggested to Patrick that they form their own region. Patrick was concerned with the issue of territory because he felt that such a region would have insufficient population to support the specialized staff required by an effective health unit. Once this was shown not to be an issue, however, he ceased to be concerned with boundaries as they related to the survival of the Timberwell Health Unit. Patrick was concerned, however, with boundaries as they related to Eaton by virtue of the unwillingness of Dr. Baldwin to either become involved in the Richlands Health Network or to consider a transfer of the town of Eaton from the Marwell Health Unit to the Timberwell Health Unit.

The town of Eaton was, so far as the Marwell Hospital was concerned, contested territory. Administrators from Eaton Hospital had ceased discussions with those from Marwell Hospital because they gained the impression that the town of Eaton would, if Marwell Hospital had its way, become part of Marwell Hospital's territory and the Eaton Hospital would cease to exist as an independent entity. Warren said that he was attracted to the Timberwell group because they talked of things that they could do for each other and of things they could do together. "We are not talking about boundaries," he said.

Winifred saw the protection of territory as being related on the need for organizational survival in the case of the hospitals and health units, but her position was one of sheer territorialism. In the case of the nursing home the territory was not defined by geographical boundaries, but by clientele. As the only formally designated long-term care facility in the area, Winifred said that she had "forced her facility's way" into the network in order to protect that position. Winifred said during one interview,

> At the bottom if it all is the survival issue. And even Patrick, at least one time, maybe more, [said], "Because you know, if we start changing our boundaries, a health unit basically has to have 50,000 population to justify an MOH." . . . As far as I'm concerned it's not survival; it's territorialism. It's about us having input into plans for long-term care in the network.

Terry was of the view that Timberwell Hospital intimidated the others "because of our large population and our large number of doctors." He saw from the beginning that territorial concerns would need to be overcome if any real progress towards the creation of an effective health region was to occur. From the outset he sought to overcame the concern with territory by the use of terminology such as "participative" in the place of "merger." During an early stage of the planning Terry told Donald that the goal should be "to give each institution identity, but to work collaboratively with a central function managed by the CEOs, collectively." He emphasized developing ownership by all of the participants in a region and service to the community. In this was supported by Patrick who was successful in making the health program approach the basis for the operation of the network.

Throughout the process of creating the health network Terry emphasized that the process should be a partnership and involve sharing between the facilities. The overcoming of the territorialism was not easy, as could be seen by the difficulties that were experienced by the participating facilities when they began to try to implement the agreement they had made. Nevertheless, the concepts of sharing and partnerships, which are a part of the organizations-as-organisms metaphor, were very prominent in the events of the case.

Partnerships and Sharing

From the outset Terry set about establishing an equal partnership between the facilities, with the aim of sharing resources so they could better meet the health-care needs of the community. As one of the participants recalled, the discussions between the facilities were based around questions such as "What can we share, what have we got to offer, what can these organizations do together?" In the way the events developed the participants seemed increasingly to regard the organizations as organic entities. They looked at how the facilities could contribute to programs and how the organizations could share functions and resources.

Much of the activity relating to these issues focussed on the behaviour of the individuals involved, and will be addressed elsewhere. The organizations-as-organisms metaphor is particularly evident in comments made by Terry late in the study when he said,

> I think what we have to do is create an environment, a desire to be involved in things and see everyone has a little piece of the action. And being equal partners and I think that brings people together as opposed to dividing them. There is strength and you always win when you work together--and you're doomed to failure if you split apart.

The sharing and partnerships that the organizations formed, the importance of boundaries, and the adaptions made to their environments were all concepts consistent with the metaphor of organizations as organisms.

Conclusion

The sharing and partnership that Terry promoted provided the means through which a health network could be created. But they were more than that. Sharing and partnership were meanings and involved values that Terry and Bobby placed on membership of an organization. They saw these as core values of the Timberwell

Senior Management Group and they brought them into the health network planning group, as each of the other participants brought their own values and meanings.

Consistent with the mechanical conception that many of the participants had of organizations, they began the creation of the new health network as though they were constructing a compact car. While Donald was leading the structuring of a plan, Terry was leading by expressing and promoting the values of cooperation, sharing, and equal partnership. The meanings and values described in the first part of the chapter can be understood as the semantics of leadership when the conceptual framework is used.

The sections of the paper that followed this first one address the way in which the participants interacted in the creation of the health network. These interactions involved the participants articulating and translating these meanings and values and as such can be understood as being the syntax of leadership. Following the low-level analysis in Chapter 4, a more in-depth analysis of the leadership was commenced in this chapter by addressing both the semantics and syntax of leadership. This process is continued in Chapter 6.

The relationship between the values and beliefs that are embedded in the culture of the health network, the translation of the those meanings through symbols and other expressions, and the resultant political action are addressed in Chapter 6. The conceptual framework which describes these issues as the semantics, syntax, and phonetics of leadership can be used to help in the understanding these processes.

CHAPTER SIX

Culture, Symbols, and Politics

Introduction

The creation of the Richlands Health Network can be understood through an analysis of the organizational culture, the symbols that were found, and the politics that occurred. Personnel from the different agencies had cooperated and worked together in formal and informal ways prior to the events of the case and this culture of cooperation was an important influence on subsequent events. Terry Neville and other senior managers from the Timberwell Hospital were important figures in the creation of the health network and the culture in the hospital had a significant impact on the newly developing organization's culture. The emergent culture developed in the way described by Morgan (1991, p. 123) "as an ethos . . . created and sustained by social processes, images, symbols, and ritual."

Symbols were important in the creation of this new organizational culture. These symbols formed an important link between the existing and the emergent organizational cultures. The health network developed from the concept of the community health campus, which fitted almost perfectly with the aims of the Minister of Health's regionalization process. The health campus vision was developed by Terry and he accepted that as the new organization developed the vision would change. No one knew what to expect when the group's proposal was taken to the Minister of Health at the October 6 meeting, or what would happen afterwards.

The uncertainty about what would occur and disagreement over what should be done resulted in a deal of political action as events proceeded. Hodge & Anthony

(1991, p. 508) define politics as involving activities designed to "obtain one's preferred outcomes in a situation in which there is uncertainty or dissensus about outcomes." Using this definition, politics was an integral part of the story of the creation of the Richlands Health Network. Throughout the story participants were striving for a variety of, sometimes competing, goals. There was conflict and Terry, in particular, sought allies and worked at building coalitions. All of these activities involved the management of symbols, which are of central importance to both culture and politics, and thus form the central part of this chapter.

These three aspects of the case that are addressed in this chapter assist in the understanding of the leadership that occurred. How they related to leadership is shown if they are considered in terms of the conceptual framework developed from the work on leadership by Pondy (1978). This relationship is illustrated in Figure 8.

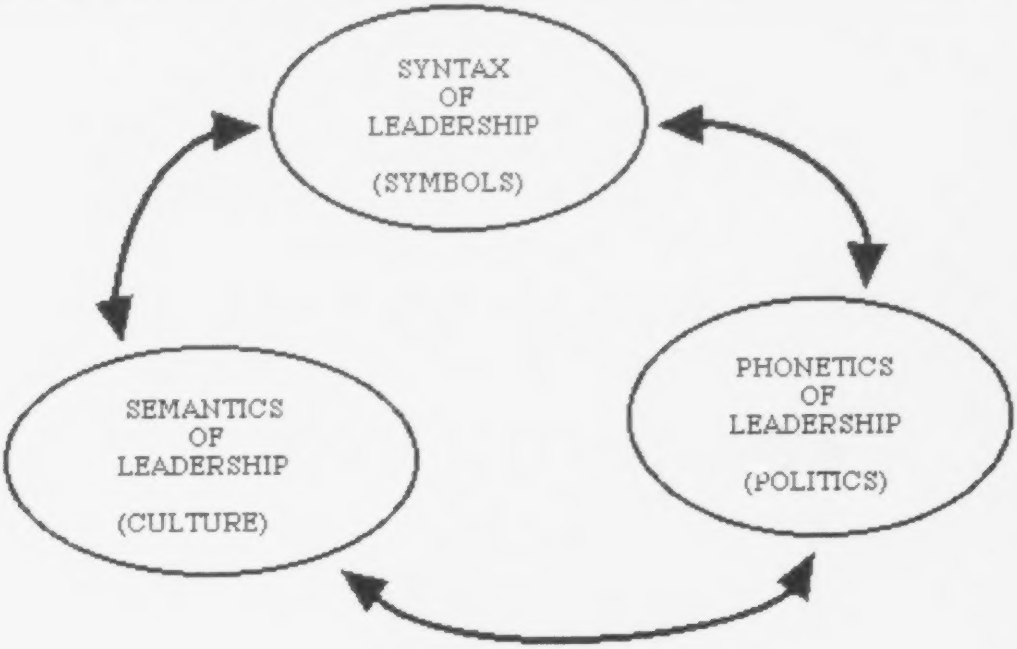

Figure 8: The conceptual framework and culture, symbols, and politics.

The Organizational Culture

The idea of the Richlands Health Network was first suggested by Terry in conversation with Patrick, on the way home from the meeting with the Minister of Health, on June 19. From that point onwards, participants from Timberwell Hospital were important in the story of the creation of the network. Terry said during his first discussion with me that he was keen to have the study done because he and the others in the hospital might learn from the study and, as a result, their organizational effectiveness stood to improve. A teaching/learning culture was evident throughout the study and this is considered in the first part of this section.

A Culture of Learning and Teaching

Terry was keen to have a study conducted into the leadership in his hospital because he said he was always trying to learn something that would help him improve his practice. He was keen that his colleagues learn to improve also. The philosophy of management that Terry espoused was that of promoting learning and facilitating growth and he encouraged risk-taking and did not worry about mistakes. "I've made some real clangers here," he said, "but I've learned from them." The approach that Terry took was that of a teacher, but he was committed to not "forcing things down people's throats." When describing his efforts in encouraging a participative approach in the hospital, on one occasion he told me, "After all it's the group that makes the decisions, I just facilitate it. They're learning, they are now beginning to ask the right questions."

Timberwell Hospital's senior managers. Terry said that he employed the best people that he could and gave them the opportunity to grow in the position. He said he never expected to keep people long because they would develop and move onto better positions and he said he did not object to that because the organization would benefit from their endeavours. Indeed, Terry expressed pleasure that "his" people received reward for their abilities and efforts.

Previous to the study two of the senior managers at Timberwell Hospital had moved on to more senior positions, one as Vice President: Finance at a major city hospital, and the other as Administrator of a larger rural hospital. During the study period, Vincent was offered a lucrative vice presidential position with an important company. When Vincent told Terry of his job offer, Terry was very supportive, saying, "The problem with hiring the best people is that they move in and out so quickly. . . . You should be excited about this. Good luck to you."

Improving management style. Terry's efforts at attempting to assist people in improving their performance or to make organizations more effective did not stop with his relationship with his fellow staff members at Timberwell Hospital. He regarded both Warren and Patrick as "old fashioned" managers who did not involve their staffs in the running of their agencies. He expressed the desire to teach each of these two administrators how they could improve their performance largely by displaying modelling behaviour in his work with the health network.

Terry described this inclusive approach in conversation with Donald, saying, "One of my goals is the need to move to a total management structure. . . . I want to get more people involved." The approach seemed to have an effect. Beryl was not involved in any of the network meetings until Warren took a short holiday and she attended on his behalf but when two of the last three meetings were held at Eaton Hospital they were attended not just by Warren and Beryl, but by two of the managers from that hospital as well.

The health network concept as a teaching tool. The teaching/learning culture was not restricted to Terry, nor to the internal operation of the Richlands Health Network. Through working on the creation of the health network, Patrick became aware that his health unit contained three distinct regions. He had become committed to the concept of the network and designed organizational structures that could be applied the two parts of his health unit outside Timberwell. He said he was proposing to set up a network in each of the three parts of the health unit. "If this thing is re-introduced we'll have a model," he said.

Terry was also committed to the model that they had developed and he regarded himself as being in a potential teaching position with regard to it. He spent considerable time speaking to Darren Pritchard and Neville Baldwin about the network proposal that the Richlands group had put together and displayed pleasure when they showed that they understood the concept and that they thought it was good. He appeared flattered when Darren asked if he could use the model in establishing a network base on Marwell Hospital and another hospital.

Others external to the participants in the study were also told by Terry about the concept that was being developed in the hope that they could learn from the experiences of the Richlands group. Further, Terry expressed the wish that following the publication of the research report that readers would gain not only from reading about the leadership and management that occurred in the process of the study, but the research report would serve as a method of making more people aware of the worth of the network itself.

The teaching/learning culture was one aspect of the Timberwell Hospital culture that flowed outside of the hospital as a result of the regionalization process. This and other aspects of the hospital's culture influenced the Richlands group as a whole.

The Timberwell Hospital Senior Management Group

Terry was described by various participants as the "key figure" in the creation of the health network, and it was his vision of a community health campus that became the centre-piece for the process. Donald played an important role in coordinating many of the initial activities including acting as secretary for the group and in writing the initial documentation and also played a leadership role in meeting--particularly at Timberwell Hospital, where the initial conceptual planning, time-lines, and organizational structures were developed. After Donald left the planning group, the documentation role was played by Bobby and she also played an important part in liaising between the members of the different organizations in the group. With people from Timberwell Hospital being so important in the development of the network, core values evident in the hospital had impact on the health network group.

Democratic values. Timberwell Hospital was chosen as the initial research site because of Terry's reputation as a democratic and participative administrator. In the initial interview he told me, "This hospital should be run by everybody. If I made all the decisions here, this place would be in trouble." Terry was able to ignore hierarchical-status differences. He described the hospital as not being managed by himself but by the Senior Management Group and he endeavoured to establish a collegial atmosphere within the management group. In addition, Terry expressed the wish to involve all hospital staff in hospital management decisions, but said he would not force them to do so.

For a long period Timberwell Hospital had operated as a highly-structured bureaucracy, regulated by rules and clearly identified line management. A more democratic organizational environment developed following the recruitment of Vincent as Director of Finance and Bobby as what was then described as Director of Nursing. Terry said, "I want to hire the best, and here average people have excelled. We attract really good people. People with goals, who know where they are going, who are consistent." Terry worked with the others in a collegial manner and the Senior Management Group, in particular, operated as a group of colleagues.

Collegiality and trust. The climate of collegiality that had developed within senior management at Timberwell Hospital led two different participants to describe

Terry's leadership as "open." The restructuring of the hospital that had occurred the year previous to the study was an example of this approach.

Vincent said, "The leadership, when I first came . . . was more of a top-down approach, and *we've* changed that. After I came *we* did some restructuring with management. *We* decided on a more bottom-up approach . . . " (emphasis added). This view was supported by other participants, an indication of Terry's willingness to accept others' ideas.

Terry described leadership in the following way,

> Leadership should involve integrity. . . . The key is to be honest. We'll take our bumps the honest way. . . . The leaders of tomorrow must be honest. If they do something questionable they must tell the people. And here the people are the staff. I push those values a lot, at provincial and at national levels. I've been called a country bumpkin because of that. If that's the case, we need more country bumpkins.

Bobby commented on the operation of the Senior Management Group by saying,

> I think that all of us feel very comfortable in discussing most issues. . . . We problem-solve very well. . . . We work well together, there's a feeling of trust in the group and what we're doing at the moment seems to be working quite well.

The formal meetings and day-to-day activities of the senior managers were themselves a reflection of the beliefs, values, and practices that comprised the organizational culture. The culture was, as described by Bolman & Deal (1991, p. 250),

> both product and process. As product, it embodies the accumulated wisdom of those who were members before we came. As process, it is continually renewed and re-created as new members are taught the old ways and eventually become teachers themselves.

Terry had stated that the hospital culture was "there long before he had arrived," and he would not attempt to impose changes on it. He had a regard for culture similar to Martin, Sitkin, & Boehm (1985), reflected in their writing, "Creating culture is like surfing. You cannot make a wave. All you can do is wait and watch for the right wave, then ride it for all it's worth."

The surfing theme was also used by Keffring & Frost (1985) in a way that can be applied to the relationship between organizational culture and the creation of the Richlands Health Network. They write,

> Thus the manager of an organizational culture or cultural change [sic] process is rather like a surfer who must ride a wave to its conclusion, always facing the risks of unexpected swirl from the depths beneath the wave as well as the unpredictable air movements on and above the surface. (p. 157)

The creation of the Richlands Health Network was unpredictable and Terry did show the commitment to "ride the wave" of the emerging network for all it was worth.

The culture that developed reflected many similar values, beliefs, and practices to those evident in the Timberwell Hospital. The Members of the Timberwell Senior Management Group became important figures in the creation of the Richlands Health Network and in so doing may have become important "teachers" in the development of the culture of this new organization.

The Richlands Health Network

Pre-regionalization links. Before the announcement of regionalization by the Minister of Health there had been no thought of formal cooperation between the two hospitals, but the individual administrators had come to know each other quite well in both formal and informal ways. Beryl had been instrumental in forming an association for directors of nursing and of this association she said,

> So we got together about four times a year and shared a lot of our services, a lot of our problems, and also a lot of the concerns we had; things we didn't understand. You know, it was a bitch session sometimes, but that was healthy, too.
>
> So it just seemed natural, from my point of view, to sort of look towards Timberwell, because I'd already established a comraderie with Bobby. Terry and Warren have always got along. They've sat together at the back of conferences--I think a lot of it was a personal thing, we felt comfortable with each other. From there it just grew.

The Director of Nursing from Marwell Hospital was invited to join the association that Beryl formed but refused, saying it was a waste of time. This comment appears to reflect a difference in the values and beliefs held by those at Marwell Hospital on the one hand and Eaton and Timberwell hospitals on the other. Given these differences it is not surprizing that Marwell Hospital did not become a part of the network, and seemed for a while to be actively opposing Eaton and Timberwell hospitals working together.

In addition to the spirit of cooperation between the two hospitals there had also existed cooperation between the administrations of the Timberwell Hospital and the Timberwell Health Unit. Dr. Smith was a newcomer to the area, and his comments on what he found are indicative of not only of the level of cooperation that was occurring between the two agencies, but the values of honesty and trust that Terry had espoused as being a basis for his actions. Dr. Smith said,

> But what I've discovered here, to my delight, is that there is a past history here of the health unit and the hospital working together, even to the point where the hospital has provided some of its resources to a community program--which is actually assisting the health unit do its job. That's an unusual event in my experience when you actually give up some of your resources. That's made it quite easy for me to work with the hospital administrator because basically I trust him, that he means what he says and that he's willing to share and work together. It's not just saying it because that's what's expected.

The most important way in which the Timberwell Health Unit and the Timberwell Hospital cooperated was through the Palliative Care Program that was referred to in Dr. Smith's comments above. This program was regarded as being very successful and became a model for the health programs that were developed in planning the health network.

The cooperative culture that had developed between the different agencies provided fertile ground for the formation of a more formalized relationship when the call for the formation of regions came and the interactions between the participants actually helped to develop and strengthen the spirit of cooperation. As Terry said on one occasion, "Everyone knows what has to be done. They've known for years, they've [just] never had a reason to do it. Now we've got a reason, so there we go." The degree to which this occurred was illustrated by the participants' reaction to the

Minister of Health's postponement of the regionalization process; they took it for granted that they would continue with their network.

The process through which the relationship between the participants from the various agencies developed was illustrated in another of the themes that emerged from the data; that of honesty and trust. These two values were of particular importance in the relationship between the facilities, particularly with relevance to the differences in status between the agencies.

Boundaries and the relative status of the agencies. With the exception of the Timberwell Nursing Home each agency had independent governance through its own board and the trustees tended to think of each of the facilities as separate entities. Each agency was individually funded and functioned independently from the others. In addition, the Nursing Home was different from the other agencies in that it was a part of a province-wide system that was administered by the religious-based Western Province Long-Term Care Organization, further emphasizing that the nursing home was different to the other facilities.

The agencies each had defined boundaries which gave substance to their separateness and any cooperation between facilities would raise possible concerns about boundary encroachments. Cooperative ventures were also made potentially difficult because of perceived differences in the status of the various agency types. The participants in the study considered that acute-care hospitals, health units, and nursing homes had different status levels.

Acute-care hospitals were regarded as the agencies that had the highest status in the health system, and the greater the number of patient discharges per year and the greater the number of physicians with priveleges to the hospital, the higher its status was considered to be. Health units were considered to be on the next status level, and nursing homes were considered to be of lowest status. The regionalization concept demanded that thinking on the basis of boundaries or status be put aside.

The Timberwell staff seemed conscious of the differences in status and were careful to ensure that a health network did not mean domination of smaller, less-well funded agencies by those that were larger and better funded. Bobby reflected on these sensitivities in saying,

> From the beginning, as I said, we were perceived that we would come on strong like a Sherman tank . . . And that hasn't happened. I think that Terry has consciously been more a facilitator than the big bully and saying this is the way it's going to happen, and I think the rest of us, too, I in my dealings with the other facilities--with the health unit--and I don't know if Dr. Smith knows this but I've worked with some of his people just on my level. And I've been very careful, even with the language you use, you come across as non-aggressive. I think that that's very important and that has really helped the situation. I think that's probably the main thing, a change in perceptions.The Timberwell Hospital Senior Management Group took a coordinated approach to establishing a trusting and non-threatening relationship with the administrators from the other agencies.

The Timberwell Hospital Senior Management Group took a coordinated approach to establishing a trusting and non-threatening relationship with the administrators from the other agencies.

Honesty and trust. At the beginning of the regionalization process, honesty and trust were not taken for granted. Warren was clearly sensitive to the concept of regionalization when he insisted on meeting with Terry in private for the meeting to discuss specific arrangements for them forming the region together. Terry set out to develop that trust, saying in July, "Another problem is that we have to get comfortable and used to work with each other and develop some trust." Beryl referred to the extent that this was achieved when, in response to a question about how the fear of take-over had been overcome, she said,

> I think just honesty, being able to talk honestly. . . . And that removed the threat, then you're talking a little more openly. Of course, no one can guarantee anything, we all appreciate that. . . . But I think we came to an honest talk. . . . So we are all working together to establish two different identities that are working towards the same goal--the community in the area.

Patrick addressed the same issue in response to a similar question. He said,

> And so you really boil it down to trust. The first part is that I've grown to trust him and take him at his word. He's shown himself to be trustworthy in all of our dealings with him. There's no evidence that he's not trustworthy. Secondly at all of our meetings he's sure that he's not overbearing of putting down any ideas. He truly is operating as one of an equal partnership.

The symbolism of action is the key to creating meaning. As is noted by Bolman & Deal (1991, p. 244), "Many organizational events and processes are important more for what they express that for what they produce: they . . . help people find meaning and order in their experience." The symbolism in the action and events was of clear importance in the planning of the Richlands Health Network.

Symbols and the Health Network

The symbolism that occurred during the creation of the Richlands Health Network are considered in terms of a number of inter-organizational relations, developing a sense of partnership, teamwork at Timberwell Hospital, Terry's willingness to accept others' ideas, and the construction as a learning process. Each of these aspects of the case assist in the understanding of the events as they proceeded.

Inter-organizational Relations

When the first formal meetings that occurred about regionalization were held, Timberwell Hospital administrators were not invited. This non-invitation symbolized the threat that those at Marwell Hospital, who arranged the meetings, perceived Timberwell Hospital to be a threat to their plans for regionalization. Warren was not happy with Timberwell Hospital's administration being excluded and took steps to see that Terry was given an invitation to future meetings, indicating that he saw that Eaton Hospital would not necessarily work with Marwell Hospital. Warren saw that there was the potential for Eaton and Timberwell hospitals to form a region together.

Donald's comment on this situation was, "It appears that [at Marwell Hospital] they were originally thinking of Eaton and Eaton's cooperation with them as a *fait accompli* . . . [and] took a heavy-handed approach with Eaton and it turned them right off." That Terry was conscious of not appearing too overbearing in becoming involved was symbolized by his not attending these first meetings personally. Donald represented Timberwell Hospital, although Terry did indicate his interest in exploring the possibilities for a relationship between the two hospitals by discussing issues with Warren informally.

A more formal liaison between the two agencies developed, but again these discussions were conducted by Bobby, less formally with Beryl, and by Donald, in a more formal way, with Warren. As Vincent commented, "When we first went into this process Timberwell wasn't accepted by any hospital." An atmosphere of uncertainty and even fear was evident and the involvement of members of the Timberwell Hospital staff other than Terry in the initial negotiations was a symbol of the non-aggressive approach to regionalization that Terry was trying to project. Sufficient trust was developed to enable Warren to request a formal meeting to discuss the creation of a region, although he was still sufficiently uncertain to demand that the meeting be held in private.

Terry's continued awareness of the sensitivity of the positions of both Warren and Patrick were shown by him not including Donald or myself in the first meeting. I was also asked not to attend the first meeting between the board representatives from Eaton and Timberwell hospitals and the Timberwell Health Unit for the same reason. Terry's awareness of these sensitivities allowed the sense of partnership to develop.

Developing a Sense of Partnership

As was discussed above, Terry used sales terminology on many occasions during the case-study period, but on only one of these occasions was the term "sell" used with regard to members of the regionalization group. On that occasion Terry said he wanted to "sell [Dr. Smith] on the partnership idea," and, "I want to sell Dr. Smith on this campus thing . . . and tell him we'll mould it to fit him." Terry expressed a willingness to seek Dr. Smith's ideas and, as events developed, displayed a willingness to accept them. These statements presented the paradox of Terry "selling" Patrick on the understanding that Patrick's ideas would count!

The way in which Terry set out to develop the sense of partnership was symbolic of his leadership style. Morgan (1991) writes in this regard,

> Authoritarian leaders "sell" or "tell" a reality, forcing their definition of a situation upon others. More democratic leaders let the reality of a situation evolve from the definitions offered by their colleagues, listening to what is being said, summoning and integrating key themes, and evoking and developing imagery that captures the essence of the emergent system of meaning. Such leaders define the reality of others in more gentle and subtle way than their authoritarian counterparts, through strategic interventions that communicate key directions and sense of value, rather than by forcing people to follow their lead. Leaders do not have to lead by placing themselves in the forefront. (p. 136)

Terry did, however, deliberately set out to "sell" ideas to the physicians, with whom he found it difficult to work, and to various people outside of the network group. In these activities he was conscious of the use of symbols to express values and signal key directions.

Symbolic language. The symbolism of language was evident in the name given to the Richlands Health Network. Patrick pointed out that they needed a name that was not associated with Timberwell, because the group was more than just Timberwell agencies and care needed to be taken to see that there was no perception that the Timberwell agencies were more important than others. He suggested "Pioneer Country" because that was the name for their tourist region. Terry supported the idea because it made it possible for facilities from the town of Marwell to be involved without appearing to be excluded or requiring a name change. In the end the name "Richlands" was chosen because it was more a generic description of the area. In addition, some administrations from health facilities in the Pioneer Country Tourist Zone opposed the creation of the health network and didn't want their membership implied by it having the name of their tourist zone.

The name for the group that was agreed to was also symbolic through the use of the word "network" rather than "region." "Network" implied a coalition, a partnership, a working together, and was therefore symbolic of the aims of the group in coming together much more than the term "region" which implied little more than an area defined by a boundary. As group members stated on numerous occasions, they were not looking at boundaries.

The name chosen for the network was very symbolic in two other ways. The initial suggestion was that the group be called a health *care* network, but the "care" was dropped at Patrick's request. He pointed out that although home care was a part of the function of the Health Unit, much of the agency's activity was directed at preventative medicine. The dropping of "care" from the name was symbolic, firstly because it presented the idea that the network was aiming at more than the care provided for people who had a medical problem, and secondly the unquestioning acceptance of Patrick's suggestion by the other members of the network was representative of the collegial atmosphere that had developed.

The symbolism of core terminology was evident with the health campus. The network was built on the health campus vision, and the term was used on numerous occasions to represent the essence of what the network was about. Terry, in particular, often used the term "health campus" to encapsulate what the group was attempting to achieve. "Health campus" represented both the process and the product of the Richlands Health Network.

Terry was aware of the symbolism of language. On one occasion he told Donald, "I don't want to go in [to meetings] and say, 'This is my agenda.' I want to get the creative juices going. . . . I say, 'Let's be proactive.'" About writing the proposal document for the region, Terry said, "We need to use the work 'creative' at least five times in the proposal." These terms symbolized the inclusive atmosphere that Terry was attempting to establish.

In his conversations with the other participants, and in telling others outside the group about their plans, Terry constantly used the term "partnership" to describe the group. Interestingly, when, in an exit interview I asked him about this, he credited the term to me. "'Partnership' was your term," he said. "It fitted, so I used it."

The symbolism of humour. Another of the ways that Terry managed symbols was through the use of humour. On humour as a symbol, Bolman & Deal (1991, pp. 266-267) write,

> Humour is a classic device for distancing, but it can also be used to socialize, include, and convey membership. Humour can establish solidarity an promote face-saving. Most important, humour is a way of illuminating and breaking frames to indicate that any single definition of a situation is arbitrary.

One of the occasions that Terry used humour as a symbol to convey membership and socialization involved Winifred. When she attended her first meeting of what was to become the Executive Planning Committee, Terry talked with her for an extended period prior to the meeting began. During this conversation he made many jokes and engaged in lighted-hearted banter and small talk. When I discussed this with him later, Terry said that he was "trying to make her feel comfortable."

Another occasion that Terry used humour in this symbolic manner involved Dr. Simpson. Like at the meeting with Winifred, Terry greeted Dr. Simpson when he arrived at the Timberwell Hospital Board meeting at which the Board was to consider formally approving the network proposal document. Terry made numerous jokes and engaged in a generally light-hearted conversation with the physician, again apparently using humour as a symbol of solidarity and partnership. On each of the occasions

Terry had used humour to address what were potentially difficult situations and to promote the sense of partnership and collegiality similar to that in the Timberwell Senior Management Group.

Teamwork at Timberwell Hospital

The degree to which the senior managers at Timberwell Hospital worked as a team was alluded to earlier with the involvement of Donald and Bobby in the initial interactions between people from Eaton Hospital and Timberwell Hospital. With regard to inter-organizational relations and more formal activities Donald played quite a visible role, whereas many of Bobby's activities were significant, but less obvious. Symbolic of the more "behind the scenes" role played by Bobby was her relationship with Janet Talbot, the Director of Home Care from the Timberwell Health Unit.

Following a Palliative Care Program meeting, Bobby expressed some dismay at the lack of knowledge that Janet had of what was occurring with the network planning. Subsequently Bobby met with Janet informally over lunch from time-to-time, to keep her informed and up to date on developments. Bobby also did a significant amount of work on the proposal document, a fact appreciated by Donald and Winifred, in particular.

In addition to these activities, the team-like functioning of the Senior Management Group at Timberwell Hospital was shown by the degree of planning that occurred in informal meetings. Many of these meetings involved Terry, but Donald and Bobby in particular, and Bobby and Vincent, enjoyed positive inter-personal relations, and Donald and Bobby often discussed aspects of the regionalization process in informal meetings. These meetings sometimes occurred in Bobby's office, but were also held in places such as the hospital cafeteria.

When the group did meet formally, their meetings occurred in a collegial atmosphere where Donald and Bobby, in particular, made significant contributions to the subject matter and direction of the meetings. Terry did not attend a number of the meetings of the Senior Management Group during the study period because of commitments outside the hospital, but this did not appear to have much impact on the functioning of the group.

On the occasions that Terry did attend, his presence did not mean that he would lead the meeting. On many occasions Donald played the major leadership role, acting as chairman and facilitator by unstated agreement with the others. Donald's role in leading discussion on the creation of a time-line for regionalization and his leading of discussion in drawing up the initial organizational structure diagram were examples of the way that contributions from all participants were considered of value in these meetings. Donald held a Master of Health Administration degree and his expertise was welcomed by the other members. The value that Terry placed on Donald's ability was shown when Terry made sure that a copy of the initial organizational structure diagram was included on the agenda of the first meetings with the other chief executives.

Dr. Simpson. The above discussion of the Senior Management group makes no reference to Dr. Malcolm Simpson, the Medical Director and a member of the Senior Management Group. At the beginning of the study, Dr. Simpson was a member of the group but not a member of the team.

His dress at the Senior Management meeting on July 8 was symbolic of the differences between the physician and the other group members. At that meeting the health administrators sat around three of the sides of the rectangular table while Dr. Simpson sat alone on the other side. He had not shaved and wore a tee shirt and thongs while the others wore the administrators' uniform of white shirt and tie, or in Bobby's case, a business suit. Dr. Simpson left the meeting early to play golf, symbolizing the low degree of importance he considered the meeting to have.

Dr. Simpson supported the concept of regionalization from the beginning because he considered administrators to be expensive and too numerous, and any reform that promised to reduce administration costs should be supported. His attitude to administrators was illustrated with the comments,

> We had a few years ago something called a role statement or mission statement and hired a consultant for two days. They all went off to decide "Well, what should the function of this hospital be?" Well, the function is to provide health care, yet it took two days--and I don't know how much this consultant cost--to decide that they're going to provide total health care!

This isolation from the other administrators changed over the period of the study. Throughout the study the administrators acknowledged the importance of the physicians in successfully establishing the network, and this important position was symbolized by Beryl and Warren asking him to address the Eaton Hospital physicians with regard to the regionalization process. Dr. Simpson asked Dr. Briggs to accompany him and Warren and Beryl were both delighted with what they had to say. This meeting was symbolic of the growing cooperation between Dr. Simpson and the other Timberwell Hospital physicians and the administrators from both of the hospitals.

He commented at the Senior Management meeting of September 9, "We should have everything down for when the new board come. We had a good meeting at Eaton. We didn't know what each other were doing. There is lots that we can do together. We've invited them to our next meeting, but the problem people weren't there."

By the end of the study period Dr. Simpson was a committed member of the network-creation team. His support for the network still centred on the reduction of administration costs and the re-direction of resources to more directly to health care and he had become a strong supporter of the concept of the network being driven by health programs. In the final interview, on October 8, Dr. Simpson was describing the health-network concept in quite glowing terms. He said,

> We haven't, of course, got into the specifics of what specific programs, it's that the whole concept has been swallowed by all the different players. And accepted. And I think that's quite a lot, actually. . . . I'm surprized it's gone as quickly as it has.
> If that's an indication of how programs would work then it's promising. If they divided up into different groups of care of programs, as Dr. Smith has outlined, and then if you could set up a committee to deal with each one, it would work quite smoothly, actually.

The idea of area-wide programs had originated with Dr. Baldwin at the Marwell Health Unit and had been introduced to the Richlands group by Dr. Smith. This was one of the concepts that was introduced and accepted for discussion by the group by someone other than Terry. Terry showed that he was always ready to accept others ideas for consideration by the group, even if he did not totally agree with them.

Terry's Willingness to Accept Others' Ideas

In beginning the process of planning for the proposed region, Terry had said that he wanted to "phase things in." He said, "I want to work on the relationships with the others, then move on. . . . They all need something that they can have ownership of. . . . I'll go through this with everyone and then ask for ideas." He declared, "These meetings where these guys sit down and create their own scenarios won't work," and he put these ideas into practice by accepting, even in cases where he was personally opposed to them, any suggestions from members uncritically and had them considered by the group.

Terry accepted Dr. Smith's proposal for district-wide health programs as centre pieces for the operation of the network. With regard to the acceptance of the health program idea, Dr. Smith said,

> Terry has the concept of the community campus, which is sort of opening the hospital to the community but that's not quite the concept of area-wide programming, but when I introduced that concept he picked up on it straight away. The way I look at it they're providing a lot of the leadership and drawing it together and operating the meetings and so on, and I've provided a little bit of the conceptual input to the way I see that we go about planning it in the future.

Dr. Smith's idea happened to fit comfortably with the health campus concept, so Terry's acceptance was not a surprize.

The same was not the case with the possibility of Marwell Hospital becoming a part of the network. Terry told Darren Eardsly, "If any one wants to get on board they're welcome. . . . We didn't chase Eaton, they came to us. Now it's up to you." To Donald, Terry had said of Marwell Hospital joining their group,

> They have to decide if they want to participate. I'm not comfortable with getting too big, but we'd be fighting our philosophy if we stopped them. They would have to make a pitch and the group would have to decide whether to take them.

This willingness to have decisions accepted for discussion by the group was also reflected when Warren suggested amendments that included Marwell Health Unit as one of the providers and also when Patrick suggested the three-level structure for the network.

These actions were symbolic in that they indicated to all in the group that no ideas would be rejected by anyone except the group as a whole and the group really was one in which no hidden agendas or threats of takeover had a place. These values took root and were evident in Beryl telling Darren Eardsly that she couldn't speak on behalf of Timberwell Hospital or any other member of the group, and with Patrick accepting Warren's suggestion that Marwell Health Unit become a part of the network.

Sticking With the Philosophy of Community Service

The inclusion of the Marwell Health Unit may have been a threat to Dr. Smith. Dr. Baldwin's apparent concern with boundaries and his unwillingness to even consider varying the health unit boundaries to accommodate the changes that were evolving may have meant that he might have been looking at taking over at least part of the Timberwell Health Unit territory as part of the Marwell Health Unit. Terry had expressed the view that Dr. Baldwin and Dr. Miller, from Pike Health Unit on the other side of Timberwell to Marwell, had a plan to each take over a part of Timberwell Health Unit territory for themselves, at Dr. Smith's expense.

Despite the possibility of these threats, Dr. Smith agreed to have the matter of having Marwell Health Unit as an agency in the network. He said that the delivery of the best possible service to the community was the goal, although he said that he didn't want a situation where medical officers of health were fighting over boundary issues.

Dr. Smith had been placed under considerable pressure by both Dr. Baldwin and Dr. Miller who accused him of "selling out" by working with Terry and the others on creating a network that involved hospitals. Dr. Smith, however, was delighted with the Minister's regionalization proposal, saying that the change in emphasis towards preventative medicine was closely aligned to "public health thinking." He said of Terry,

> He's one of the hospital administrators, of all the ones that I've met, that the community concept is there and has formed in his mind. It makes it very easy to work with him because I don't have to convince him to look at the community, he's already doing that. All we have to do is to look and see how our different ideas and things can be put together and make it operational. So we are already at the stage where we can see how we can operationalize some of these concepts.

Both Patrick and Terry were willing to work as a team and to use an open approach. This openness was a part of the proactivity that became a hallmark of the health network group as it developed. The willingness to innovate and create change for the better was central to the thinking in the health network. The pursuit of these goals resulted in no small degree of political action.

The Politics in Creating the Health Network

The announcement that health regions were to be formed created an essentially political environment. The decision as to with whom to negotiate was left to the individual health administrators and as Morgan (1991, p. 147) writes, "It is clear that organizational choice always implies political choice," and "politics will occur where people want to pursue divergent interests" (p. 153). Politics were clearly involved with the exclusion of Timberwell Hospital representatives from the initial meetings involving Marwell Hospital, Marwell Health Unit, and Big Deer and High Valley hospitals.

These meetings marked the initial "jockeying for position" as the various administrators sought the most favourable conditions in the formation of the health regions. (Bolman & Deal, 1991, p. 186) propose the concepts of jockeying for position, enduring differences and the allocation of scarce resources, conflict and power, and coalitions as summarizing the political perspective. Each of these was present in the case of the Richlands Health Network.

The most significant person in the politics that occurred in the case was Terry, described by Bobby as being "much more politically astute than probably all of us and he knows how to go about solving something." Long before the beginning of the case-study period Terry sought to establish a network of contacts that could offer support in the continued existence of the hospital, which was one example of how Terry often sought to address political problems by coalition-building. Morgan (1991) describes this type of activity as being that of "the skilled organizational politician . . . who systematically builds and cultivates . . . informal alliances and networks" (p. 173).

The building of alliances and the creation of networks are essentially creative activities but coalitions are also tools for building up strength and power. The chances of prevailing where conflicting goals exist or when there is competition for scarce resources can be improved if alliances are made. The events in the study showed both enduring differences and competition for scarce resources.

Enduring Differences and the Allocation of Scarce Resources

Underlying the entire process of regionalizing health in Western Province was the issue of resourcing the health system. The Minister of Health called for "fiscal resolve" and "discipline" and the need to "ensure we spend the dollars more wisely than we do now." The forecast cuts in the health budget which appeared in the government's five-year fiscal plan created the expectation of an increased scarcity of resources for the health sector. In addition, the recently introduced methods of calculating funding for acute care were based on competition for funds between hospitals.

According to the Minister of Health the "fundamental reform" that was to take place demanded "that future groupings of services be truly multi-sector in focus" and challenged the old assumptions about facilities having individually operated budgets being governed by separate boards. In addition, the implied modification to how funding was directed to the various sectors of the health system implied possible increases in funding to those agencies that had previously received low levels of funding at the expense of those that had been previously relatively well funded. No one knew just what to expect.

Support for regionalization from within the network. Terry's response to the directives on regionalization was to regard the situation as an opportunity, saying, "Let's look at solutions, not problems." Behind the Minister of Health's plans were the the objectives of a greater emphasis on preventative health care and multi-sector groupings providing a continuum of service for the community. These bore a remarkable similarity to those proposed in *Community Health Campus: Draft* Terry had written several months before the Minister of Health's announcement of regionalization.

Terry said "This is a golden opportunity for us to do things we always wanted to do but in the past we haven't been allowed to," and the positive regard for the regionalization concept was shared by the other members of the health network. Warren commented, "If this [regionalization process] didn't occur we should do this anyway. We should have done this a long time ago."

Opposition from Dr. Baldwin and others. By contrast was the reaction of Dr. Baldwin, who made numerous contacts with the participants stating his opposition to their plans and who placed great pressure on Dr. Smith in the attempt to have him cease cooperating in the networking process. In the end the Marwell Health Unit was added to the list of Richlands Health Network health providers because the group members had the impression that that was what Dr. Baldwin wanted. Dr. Smith reported Dr. Baldwin's reaction; "He wants his name taken off the document. He says that if it's there it implies he approves of what we're doing. . . . I'm getting hell!" The differing beliefs, values and goals of the network members and Dr. Baldwin resulted in on-going conflict.

Other health administrators questioned the Richlands Group approach but because there was no competition between them, conflict did not arise. At the Eastern Region Planning meeting at Loon Lake, where Patrick, Warren, and Bobby talked about the network they reported that many of the people didn't seem to understand what they were attempting to do. The reactions of the others at the meeting were described by the Richlands people as, " They kept getting piled up . . .," "They didn't quite get the message," and, "They didn't seem to grasp where we were coming from. . . . That we were spinning our wheels and we wouldn't get what we wanted." The apparently differing beliefs, values, and understandings between these other groups and the Richlands people meant nothing more than lack of understanding.

The Loon Lake meeting was attended by a number of provincial politicians from the area. They were opposed to the regionalization concept and urged health administrators and trustees that opposed the concept to write to both the Minister of Health and the Premier stating their opposition. A Member of the Provincial Cabinet that was present went as far a saying that people should simply refuse to comply, introducing the concepts of conflict and power.

Conflict and Power

Bolman & Deal (1991, p. 196) identify the most significant forms of power as being position power (authority), control of rewards, coercive power, alliances and networks, information and expertise, access to and control of agendas, the control of meaning and symbols, and personal power. The control of the first three of these lay with the Minister of Health, and all three were used in promoting the establishment of the health regions. Terry had shown in his past that he was not adverse to the use of power when he saw that it was necessary. The Director of Nursing prior to Bobby was, according to members of the nursing staff, both popular and effective. However, because of his highly external role, Terry desired a Director of Nursing who was a "team player" who pursue issues other than those that were purely nurse-focused. Much to the dismay of the nursing staff, he dismissed this Director of Nursing. These forms of power were not available to those expected to create the health regions, however.

The successful creation of a health region required much more subtle methods. The differences in status of the different agencies, the governance, and financing of the agencies as separate, independent entities referred to above, and the tendency of those in the agencies to be protective of their boundaries, made health administrators sensitive to issues of power and authority. Terry, as the initiator of the health network used more politic methods.

He made use of alliances and networks and symbols in working towards the creation of the health network. The encouraging the sharing of information and expertise as a premise on which the network was built and the ensuring open access to and control of agendas became symbols of the equal partnership that had become the catch phrase for the network group. The development of coinciding values and beliefs made the creation of coalitions a possibility. Within the health network Terry encouraged the creation of shared meaning based on these values and beliefs and outside the health network he was active in the pursuit of these commonalities as he sought to gain as many allies as possible.

Coalitions and Coalition Building

In building and maintaining coalitions Terry liaised with individuals and groups both inside and outside the network. Terry appeared to accept the proposition that "organizational goals are set through negotiations among members of coalitions" (Bolman & Deal, 1991, p. 190). At all times in the case-study events Terry attempted to make everyone understand that he wanted to avoid imposing goals on anyone and that all decisions about the health network would be negotiated among the network members. The coalitions that Terry sought included ones with the health administrators and the physicians inside the network, and hospital administrators, planning officials, and Provincial Health officials outside the network. He also embarked in coalition-building in the sense that he sought to overcome potential conflict by being supportive of potential adversaries.

The physicians as allies. Terry was aware of the need to gain the support of the physicians if any newly created region was to be successful and made continued reference to the need to "get the doc's on side." The visit by Dr. Simpson and Dr. Briggs to the medical staff meeting at Eaton Hospital showed they were supporters of the health network concept and they were critical of the Eaton physicians who opposed it. In referring to the meeting, Donald said,

> Bobby says it was a dilly! Warren and Beryl said that Dr. Simpson and Dr. Briggs told them what they had been trying to tell them for a number of years. They [Warren and Beryl] loved it! They told them some real home truths.

Warren said of Dr. Simpson and the meeting, "He was good. He was saying what we've been saying, but it was a peer telling them."

Some of the physicians had been critical of Donald being employed and not being seen to have been doing anything regarding acute-care funding. Such was Terry's desire to the support of the physicians that when he was presented with the opportunity he had no hesitation in removing Donald from the planning activities and having him concentrate on acute-care funding. He told Donald they should work with Loren, the Nursing Supervisor, and Dr. Briggs, in addressing problems regarding funding. In so doing, Terry said that he would check that this arrangement had the agreement of Dr. Simpson.

In referring to the need for support from the physicians Terry described them as being "grass roots," in apparent agreement with Bolman & Deal's (1991) assertion that "organizational goals arise not from fiat at the top, but from an ongoing process and interaction among the key players in any system " (p. 189). When the meeting with Jim Perich was arranged Terry asked Malcolm Simpson if he would like to talk with him with the possible aim both of showing Mr. Perich that the physicians, through the Medical Director, were in agreement with the network planning, and of indicating to Dr. Simpson that Terry valued his participation. By making the offer Terry was strengthening the coalition with Dr. Simpson and improving the opportunity of developing a coalition with a senior Provincial Health official.

Allies outside the health network. For a number of years Terry had seen the need to develop a network of allies in senior positions. He was an active member of the Association of Hospital Administrators and was a member of the strategic planning committee for Amalgamated Hospitals Group, both or which assisted in creating and maintaining this network. He saw that powerful allies outside the network would be important so that the chances of the government accepting their relatively small regions would be improved. Terry described the network concept to others and sought support from the likes of John Holt, the CEO of the Amalgamated Hospitals Group, Peter Goldthorn, the Chairman of the La Fontaine Health Planning Group, and Doug Cosgrove, the Assistant Deputy Minister of Health in addition to Jim Perich, from Provincial Health, referred to above.

These coalitions were sought through formal approaches, but Terry also sought to develop alliances through less formal means. He was the chairperson of the Mud Creek Inter-agency Committee which was not only symbolic of him being a a leader in promoting cooperation between health agencies, but allowed him to play a host role before and after such meetings. Both Terry and Patrick had stated on a number of occasions that the inter-agency group had an important role to play in the health network. Warren had planned to attend one of the meetings to see whether agencies from the town of Eaton would be welcome to join.

Terry used similar informal methods to develop the support of others before and after meetings, by making telephone contacts with people he saw as being significant, and by engaging in in informal conversation and banter with physicians and staff members in the hospital. He engaged in personal interactions with people in ways such as assisting the maintenance supervisor at the hospital in some construction work and by designing a wine rack for one of the physicians who was moving into a new house.

Conclusion

The development of the Richlands Health Network saw the emergence of a new organizational culture as personnel from four different health agencies cooperated in a common purpose. The new organization was built around the vision of a health campus that was proposed by Terry Neville a number of months before the Minister of Health announced the plans for the regionalization of health in the province, and before the events of the case study.

As the events of the case study unfolded a set of values and beliefs developed in the new group and a shared meaning of what the new organization was to be emerged. Symbols played an important part in the development of the health network and political activity was an essential part in the process. Culture, symbols, and politics provided a framework for the themes that emerged from the research data. The analysis in this chapter drew out the importance of vision and the creation of a shared meaning, which are central issues in the study of leadership. Leadership emerged as the issue that tied these themes together and is further analyzed in the following chapter.

CHAPTER SEVEN

The Leadership

Introduction

The decision to form a health region based on the Timberwell and Eaton townsites and the planning for the resultant health network were the culmination of events that took place over more than a year. The planning of the health network involved a response to change, the formation and communication of a vision and the modification of that vision, and the creation of a shared meaning. The literature identifies each as an issue relating to leadership.

The health network was first suggested by Terry Neville and he presented his vision of a health campus as the vision for the health network. The participants in the study of the Timberwell Health Network agreed that Terry was a leader in the planning process, but he was by no means the only leader and, so far as some of the participants were concerned, after the initial stages was not the most important of the leaders. As the events of the case unfolded leadership appeared to emerge "as a communal endeavour" (Foster, 1986) or as "consensus or collegial leadership" (Van Fleet & Yukl, 1989). Certainly, what Van Fleet & Yukl (1989, p. 75) describe as "where one person dominates, a conventional view of leadership exists" and there is an implicit and often explicit connection between leadership and position, does not apply in the current study.

This chapter is organized around the conceptual framework which was developed from the concept of leadership as language proposed by Pondy (1978). The vision proposed by Terry Neville comprises the central part of the syntax of the leadership. The participants' understandings of their worlds and the associated values are issues of importance in the semantics of the leadership. These issues were addressed in some detail in Chapter 5 and in the sections on culture and symbols in Chapter 6. In this chapter the way in which the concept of a community health campus was presented as the vision for the health network and how the various participants' understandings were drawn together to become common meanings are considered. Numerous individuals in the case provided leadership, and the way in which they expressed their leadership related to their view of the world and their place in it. This leadership behaviour, the phonetics of the leadership, is also analyzed in this chapter.

The Semantics of the Leadership

Meanings and Values

With the announcement of regionalization Terry presented his concept of a health campus as the vision to guide the creation of a health region based around Timberwell, but in so doing accepted that he should not hold a dominant or overly influential position in the planning process. The reasoning behind this position was partly because Terry knew that the high number of patient discharges and large number of physicians with privileges at Timberwell Hospital would make other administrators wary of the threat of being taken over. From a pragmatic perspective, Terry needed to take an obviously non-threatening stance if his overtures for the creation of a region were to be successful. Terry's understanding of leadership, his willingness to accept others' views, and to not resent others' suggesting changes to his vision were in synchrony with the requirements of the situation.

The fear that two or more health agencies working together would mean the take over of the smaller and less-well funded by the bigger and busier was a reflection of the traditionally bureaucratic nature of hospitals and the way that many people regarded them. As is noted by Wilson (1992), "Cost effectiveness is widely accepted as the most prevalent acute-care hospital challenge. . . . Hospitals have been criticized for continuing to have hierarchical chains of command with essentially bureaucratic structures" (p. 4).

In her study of attempted change implementation in a large hospital in western Canada Wilson (1992) found that

> barriers to change can be expected to originate from all levels of an organization. Managers may be more willing to embrace a paradigm shift if they understand the need for it and recognize how it may be implemented. . . . The positivistic paradigm, synonymous with traditional bureaucracy and hierarchical control, continues to be prevalent in this particular nursing organizational structure. . . . Those who may be reluctant to relinquish the existing structure are the managers responsible for initiating and implementing change. (p. 8)

To successfully embrace other administrators in negotiations Terry not only had to overcome the fear of organizational take over but had to deal with the kind of paradigm shift referred to here by assisting people to understand the need for change. He was equipped to take a collaborative approach, as was illustrated by the way that the working and personal relationships had developed within the Timberwell Hospital Senior Management Group, and his leadership style suggested that he was in agreement with the sentiments expressed by Foster (1986) that, "leadership is a communal endeavour wherein the direction of the society is discussed and debated. Leadership, in this respect, resides in actions and acts, not persons and positions" (p. 18).

By encouraging the planning of a health region as a communal endeavour Terry was facilitating the establishment of a situation where the values, beliefs, and understandings of each of the participants could be taken into account. The conceptions that they each had of their world, their organizations, the health system and their place in it, and of leadership itself, would be included in the semantics of the conceptual framework being used for this study. To form a cohesive group the participants would have to come to a shared meaning about these issues.

Adair (1980) describes three essentials for such a group: the need to accomplish a common task, the need to be maintained as a cohesive social unity, and the need to take into account the individual needs of the group members. "With regard to the third area, it may be noted in parenthesis, that experienced leaders in all periods of history have realized that man does not live by bread alone" (Adair, 1980, p. 9). The participants' needs included both lower-level and higher-level needs referred to by Maslow (1954). These needs included low-level needs such as retention of their jobs and the survival of their organizations and higher-level needs such as participating in a group that would result in the formation of an organization that would allow more effective and efficient health service delivery. Essential values for what was to become the Richlands Health Network were sharing and equal partnership and the creation of the regional group as a collaborative enterprise.

Collaboration and Partnership

To emphasize the collaborative nature of his proposal Terry said that he envisioned them forming an equal partnership. He made the partnership concept a central part of the vision for the health group they were planning. In so doing he expressed a willingness to share the leadership with others.

Collaboration was essential to the development of the health network anything other than a collaborative, non-threatening approach would have been unsuccessful. Terry said that he believed that management should be a collaborative enterprise and he had a history of putting such an approach into practice. This reputation helped make his overtures to the other participants successful. He developed credibility, which is referred to by Kouzes & Posner (1987) when they state, "According to our research the majority of us admire leaders who are honest, competent, forward-looking, [and] inspiring" (p. 16) and "together these characteristics comprise what communications experts refer to as 'credibility'" (p. 21).

As Donald described Terry's actions during the network-planning process,

> Perhaps the way he shared leadership was in essence by not taking it on himself and not consciously trying to lead the way, and that sort of thing. . . . [S]tepping back and taking a low-key approach may have been the way he shared leadership in the process. Because, I suppose, it could have gone many different ways if Terry had acted differently. It might have scared off Eaton if he'd taken too high-handed an approach. I think he was very conscious of that. He had to court Dr. Smith a great deal, and is still doing so even now, that is, consulting with him before moving on with getting this financial position filled. So there's that sort of approach, those sort of mechanics to which I was exposed. That's really about what he did.
>
> What he didn't do was, of course, important. . . . In terms of taking a taking a high approach, of doing a hard sell on the document . . . those sort of symbolic things that are probably quite important. . . . He did not chair all the meetings, he did not call all the meetings, that's the sort of scenario I'm talking about.

The "low-key" approach that Terry used was successful in not frightening potential participants away but in addition meant that he was prepared to accept suggestions that he himself was not sure would benefit the network. He was prepared to make Marwell Hospital welcome because to refuse to do so would have been "fighting our philosophy" and would have been in contradiction to the core value of collegiality.

Terry was also attempting to improve the way in which the health agencies provided for the health needs of the community. The collaborative approach made the negotiations on the formation of the network possible. There was a degree of coercion in that the Minister of Health had stated, "If the collaborative approach does not result in fundamental change, government will have no option but to consider other more prescriptive options," and this tended to increase the appeal offered by Terry's non-threatening approach. He presented a vision that was directed at core values which the participants were likely support, and at the same time presented a vehicle which could greatly improve the chances of each of the agencies of continuing as relatively autonomous entities.

The proposal for regionalization was described by the Minister of Health as a "paradigm shift," and for many it was a new way of thinking about health care. Terry had pre-empted the Minister of Health's call for new thinking about health care when he produced *Community Health Campus: Draft* and the announcement of the Provincial Government' policy of decentralizing the health system presented Terry with a scenario in which he could show leadership in guiding others to a new understanding of what health care could or should be. As Kotter (1990) remarks, "Since the function of leadership is to produce change, setting the direction of that change is fundamental to leadership" (p. 104). Terry set a direction and played a complementary role with other participants in the way Kosowski et al. (1990) define a leader as one

> who has the ability to create a shared sense of reality and who plays a complementary role to the members in the leadership process. . . . A member is one who facilitates accomplishment of the focus or vision of the group and plays a complementary role to the leader in the leadership process. Members respond to the leader's vision and unify their efforts in its direction. (p. 39)

"Vision" is part of the syntax, which in Pondy's (1978) words, operates "to translate [meanings or values] into stylistic representation" (p. 89).

The Syntax of the Leadership

The Vision

Vision has a prominent place in the literature on leadership. Bolman & Deal (1991) comment,

> The last decade has spawned a series of studies of "good leadership" in organizations, particularly in the private sector. . . . Vision is the only characteristic of effective leadership that is universal in these reports. Effective leaders help to establish a vision, to set standards for performance, and to create a focus and direction for organizational efforts. (p. 411)

Community Health Campus: Draft, which became the vision statement for the health network, had been written by Terry Neville some six months previous to the

Minister of Health's announcement that the health industry in Western Province would be regionalized. He had prepared *Community Health Campus: Draft*, his vision for the health sector in Timberwell, because of concern for the survival of the hospital. The document was accepted in principle by the Timberwell Hospital Board largely because it was seen as a possible way that funding for the replacement of the existing hospital building would be provided by the government.

Until the Minister of Health's announcement *Community Health Campus: Draft* had little impact. Terry had gained support in principle from the Timberwell Hospital Board and had distributed the document widely but he had not taken it into the hospital and communicated his vision to the hospital staff. *Community Health Campus: Draft* was a predictor of the way in which the operation of the Timberwell Hospital would tend, particularly with regard to ambulatory care. Vincent said,

> So I think our vision was to keep some of those community bases, but to be more forward thinking, looking to the future, to ambulatory care. And that's what we were striving for. The numbers actually show that. Our out-patient numbers are very high.

Bobby made similar comments, saying,

> I think, right now, the role or the vision has been that it will be more a family practice; community oriented. There has never been any talk about becoming more specialized and I think that at one point the Board had hoped that we would really go out and have a bigger facility . . . and I think that with the fiscal climate in Western Province that's never going to happen. We're becoming more settled with the fact that we've a small in-patient and that our out-patient and ambulatory care is . . . of the fact. And that's what we can do and what we can offer. . . . And what we have from Provincial Health is the maximum we'll have. . . . My impression is that that's enough. . . . What we'll have around here is a more efficient, larger-space emergency/out-patient clinic care.

These sentiments were a reflection of the intent of the health campus document and, in addition, were representative of much current thinking with regard to required or desirable changes in health care (Armitage & Bain, 1992; Bezold, 1992; Bridging the Gap in Healthcare, 1992; Johnson, 1991; Moeller & Johnson, 1992; Vladick, 1992; Wolford, Moeller, & Johnson 1991). In addition, the intent of *Community Health Campus: Draft* bore striking similarity to the Minister of Health's vision for health care across the province which included "effective use of resources and access to a spectrum of health services" and "greater emphasis on health promotion and disease prevention."

The Minister of Health's vision would have an expected appeal to health unit administrators. Dr. Smith said following a Provincial Health Department workshop on regionalization,

> It's what the government has done in their rhetoric. At one of the meetings I did get up and say that this was the first meeting I have ever attended where what I called the public health rhetoric was being promoted as the way to go. They were talking about the paradigm shift from the institutions to the community on the overhead. So the right-hand column was our public health rhetoric. We were quite pleased by all that.

These sentiments are an illustration of the degree of similarity between the Minister of Health's vision and that of Terry. Terry said of his vision,

> I don't see a strong emphasis on hospital beds. I see an emphasis, because of the nature of the people here, on adult education programs; community-based programs, a very strong relationship with other providers' programs; better coordination of what we do so that people can knock on anybody's door and we can direct them to the appropriate service so they don't have to jump through hoops. . . . I see us being more involved with some of the preventative [medicine] with the Health Unit, more of a common purpose over the next ten years. . . . To start thinking . . . beyond the walls, to start looking beyond the walls.

The ideas that were contained in *Community Health Campus: Draft* were not original, and Terry did not claim that they were. On the writing of the document he said,

> I had to show them a new vision, a new light. I said there's a whole pile of stuff that's out there that's happening right, that has credibility. Get some papers on it, put it together and write an article so that you can structure a vision. . . . It's not a new idea, there are a few of them in the States that are extremely successful.

What *Community Health Campus: Draft* did was present ideas that were "in the air," and the development of the health network, from the preparation of *Community Health Campus: Draft* to the finalization of planning. Figure 9 shows how related ideas from different sources were factors in the formation of the Richlands Health Network. The arrows in Figure 9 indicate the general flow of events and the relationship between the different issues was not totally linear.

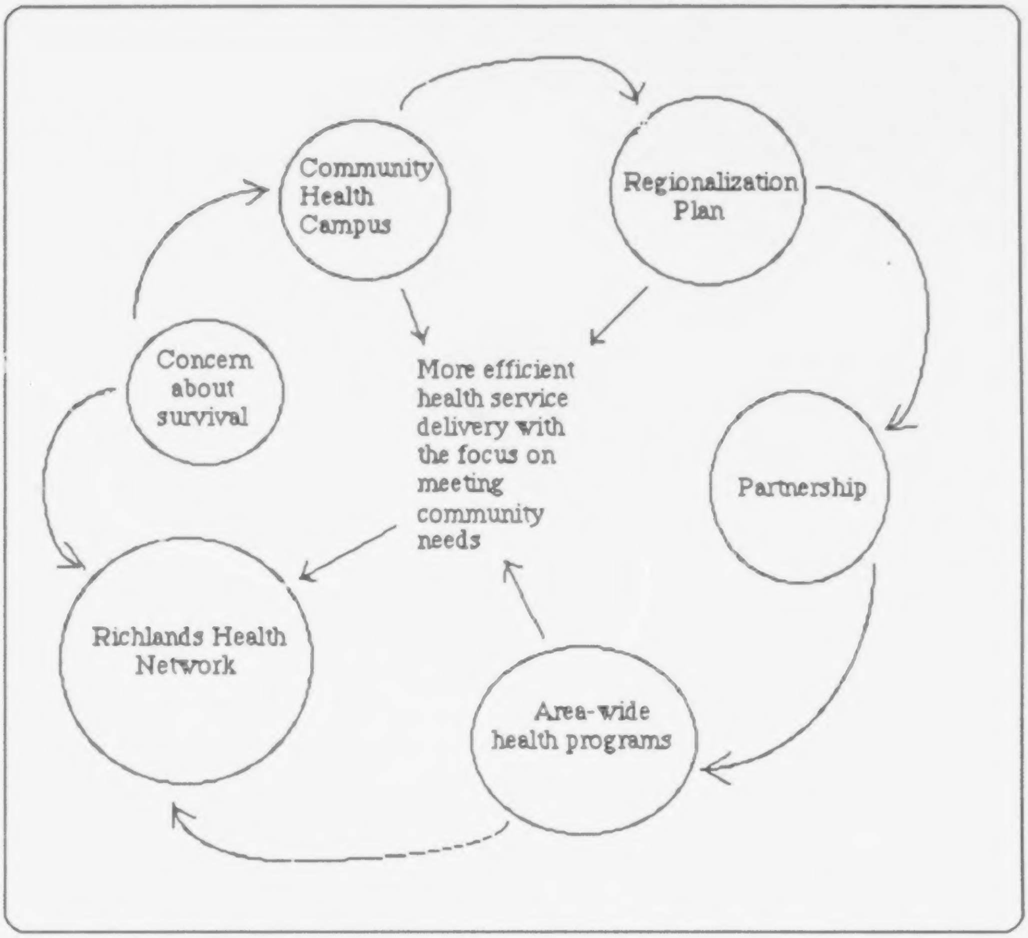
Community Health Campus
Regionalization Plan
Concern about survival
More efficient health service delivery with the focus on meeting community needs
Partnership
Richlands Health Network
Area-wide health programs

Figure 9: The health network planning cycle.

Levey (1989) writes, "New ideas are often discovered by several people separately at the same time--they are 'in the air' in some sense. The shared environment is also essential if a person with a vision is to become a leader" (pp.136-137).

The ideas from the health-care literature that were expressed in Terry's health campus vision were evident in the Minister of Health's vision for regionalization and were also reflected in the rationale behind Patrick's concept of area-wide programs. Ideas from these sources were combined in the vision for and the planning of the health network. The finalization of plans for the health network "closed the loop" in an interesting way, for as Figure 9 illustrates, the concept of the health campus was born with concern about the future of Timberwell Hospital and an important part of the agenda for the creation of the health network returned to that issue; the survival of the hospitals.

Survival was an important motivator for Terry preparing *Community Health Campus: Draft* and survival was of importance for those that became involved in the health network, but the community health campus concept was directed at higher-level needs than just survival.

The health campuses in the United States that Terry modelled his vision on had proved to be successful because they directed the delivery of health care at community needs. The health network participants were aware that the regionalization of health care could result in a number of them losing their jobs but they pursued the health campus vision because its achievement would mean that the health needs of the community would be better met. This led them to transcend their personal needs in a way described by Rosenbach & Taylor (1989a) when they write,

> Transformational leadership involves a strong personal identification with the leader; group members join in a shared vision for the future--going beyond self interest and exchange of rewards for compliance . . . creating a shared awareness of the importance and value of designated outcomes; influencing followers to transcend their own self interest; and altering or expanding motivations to the higher orders of self esteem and self actualization. (p. 152)

Terry, Bobby, Warren, and Beryl all said at different times that the creation of the health network could provide a real threat to their positions. Dr. Smith pursued the concept of the health network in the knowledge that its implementation could well mean significant organizational changes for the Health Unit. He did so in the full knowledge and despite the persistent criticism of fellow Medical Officers of Health who did not want to see health units change.

The transition from seeking to satisfy lower-lever needs at the initial stages is described by Sergiovanni (1991) as "bartering," the first of four stages of leadership. The second stage, described by Sergiovanni (1991) as "leadership by building [when] the focus is on arousing human potential, satisfying higher-order needs, and raising expectations of both leader and follower in a manner that motivates both to higher levels of commitment and performance" (p. 126). Transformational leadership was also present with bonding and banking, the third and fourth stages of leadership that Sergiovanni (1991) suggests, but these would occur at the implementation and institutionalization stages of a change process. As the current study was of the health network's planning stage, these final two stages of leadership are not addressed here.

Keenhert & Lewis (1989) suggest three stages in a "constructive/developmental analysis" of leadership that presents similarities to that of Sergiovanni (1991), above. These authors suggest two stages in which transactional leadership is apparent. "Imperial" leadership, where the organizing process involves personal goals and agendas directed at perceptions, immediate needs, and feelings; and "Interpersonal" leadership, where interpersonal connections and mutual obligations are the subject and personal goals and agendas are the object of behaviour. The third of Keenhert's & Lewis' (1989) stages is "Institutional" or transformational leadership, where the leader's behaviour is based upon personal standards and value systems and is directed at establishing interpersonal connections and mutual obligations. Like the stages suggested by Sergiovanni (1991), events in the current study could be described using these stages.

When Terry proposed his vision of a health campus as the basis for the proposed region there occurred what Handy (1989a) describes as the "ah ha effect" when, "a leader shapes a shared vision that gives a point to the work of others. . . .

The vision must be different . . . [but] must make sense to others" (pp.238-239). Bennis (1990) makes a similar point when he states;

> The leader knows what we want and what we need before we do and expresses those unspoken dreams for us in everything he of she says or does. When Martin Luther King spoke of his dream, for a moment, all of us, black and white, were one. . . . Deep in all of us there is still and always a need to believe, and one day a leader will appear who will express that need, and fulfil it. (p. 159)

If leadership means the creation and communication of a vision, as described by the likes of Burns (1978) and Sergiovanni (1991) then Terry Neville was a leader in the Richlands Health Network, but from the beginning he made it clear that he favoured a collaborative approach, and as the planning proceeded it became clear that Terry was not the only visionary. The leadership that occurred in the planning of the Richlands Health Network involved praxis, as described by Foster (1986);

> Praxis is the recognition that theory must eventually be located in sensuous human activity. The test of theory is its eventual relevance to improving human condition. . . . Praxis, in this respect, stands for the ability of all persons to engage in acts of leadership which help in the transformation to a way of life which incorporates participative principles; leadership, in this regard, is both critical and a shared leadership. It is shared because no one individual has the right way. (p. 14)

In the development of a shared meaning in the process of planning the Richlands Health Network Terry presented the opportunity for all participants to share in the leadership. Terry presented ideas, asked questions, and invited others to respond. Together, the semantics and the syntax of leadership interacted and resulted in the observable behaviour, the phonetics of leadership, the various participants contributed to the planning process and the creation of a new culture.

The Phonetics of the Leadership

The phonetics of leadership was the action, the observable behaviour of the participants in the case. The leadership activity was collaborative and involved a mutual dialogue between those involved. The interactions began with the needs of the participants being addressed and the development of the vision and the planning for the health network became the expression of a number of core values.

A Mutual Dialogue

In order that real planning for a health region could occur a group culture had to develop--in the way referred to by Schein (1985) as going beyond the artifacts to the development of common beliefs and assumptions. Kreffing & Frost (1985) refer to this in writing, "Organizational culture is often described as shared meanings--patterns of beliefs, symbols, rituals, and myths that evolve across time that function as the social glue" (p. 155). An essential in this process was Terry's desire to, as he described, "let the creative juices flow" and to develop in the participants an "ownership in the process." Terry did not show any ego-attachment to the vision and communicated that he did not consider the modification or criticism of his ideas to be a threat.

From the outset he saw the vision of the health campus as a starting point that would be modified as time went by. He said of Dr. Smith that they would "mould the vision to fit him" and Terry was also aware of providing the opportunity for real input into the process to Warren, Winifred, and the other participants. Terry aimed for leadership called for by Smyth (1986) which would mean "the abolition of privileged and elitist forms of leadership . . . and for their replacement with a form of leadership that stimulates dialogue and mutual learning" (pp. 6-7). This type of leadership is described by Burns (1978) as transformational leadership and as he stated in an interview (Goodwin, 1978),

> The sources of both leadership and followership lie in a vast pool of human wants, and the transformation of those wants into social aspirations, and political demands. . . . True leaders . . . emerge from, and always return to the wants and needs of the followers. They see their task as the recognition and mobilization of their followers' needs. . . . In this engagement with their followers, the leaders' own motives are altered. They may be transformed just as followers are. Both leaders and followers may be transformed to the point where followers become leaders and leaders followers. (pp. 47-8)

Beginning with Members' Needs

The organizational needs of the administrators from the institutions were described by the participants as: the survival of Eaton Hospital by increasing the numbers of patients, programs, and services in the hospital; ensuring that those from Timberwell Nursing Home would have a say in the provision of long-term care in the area and decisions on long-term care matters would be made by those trained in administration of long-term care programs and operating facilities designed for long-term care; and the provision of a more effective system of health care through improved preventative medicine and collaboration between the Timberwell Health Unit and various health care agencies in the area--which would assist in the achieving the mission of the Health Unit in promoting health and well-being in the community. Each of these were taken account of in the process of planning the health network.

The degree to which the needs of the various participants were addressed would prove to be the determinants of the extent to which the participants became a part of the organizational culture. The emphasis in the planning had been on people rather than structures and this provided a reason for the success of the planning process. The Maxcy & Caldus (1988) suggestion that "leadership be reconstituted to reveal the pluralistic meanings currently displayed by that concept; to recognize that leadership may be shared and that leadership in a democratic society requires followers be treated as ends in themselves, rather than means" (p. 26) appears to apply.

An essential part of the way that Terry expressed his leadership was described by different participants as "open." Owen's (1991) observations that

> leadership, when explicitly described as a moral activity, requires being open to the limitedness of one's perspective and encouraging others to do the same. The process of the mutual offering of perspectives, that is, of critical dialogue, is what distinguishes leadership from power wielding. (p. 3)

Terry always showed a willingness to listen to others and to accept their ideas and, as Mazlish (1984) asserts, a leader "does not exist fully formed until the encounter with the group" (p. 13). Furthermore, in the context of the threat that many perceived the Minister of Health's regionalization policy to represent, and where many administrators saw themselves in competition with those from other agencies, any implication of power-wielding by one party would quickly result in a breaking-off of dialogue by others. The circumstances demanded an openness and honesty in approach as referred to by Bennis (1989) when "environmental encroachments and turbulence, . . . the fragmentation of constituencies . . . multiple advocacy, win-lose adversarial conflicts between internal and external forces . . . has led to a situation where our leaders are 'keeping their heads below the grass,' as L.B.J. once put it" (p. 12). Terry said during one interview,

> I see this as a very long process because there are a lot of people that are going to work together that have been very adversarial and competitive over the years and have a different mind set. It's got to be a team not just within institutions and not just in the cultural sense, but in the building of bridges and relationships and in terms of people that have traditionally not worked together for a common goal.

Terry repeatedly stressed the need for equal partnership and collaboration and seemed to reflect Zaleznik's (1989a) comments when he writes,

> Leaders centre their assumptions on people--why they act as they do, what they think, what is important to them--rather than on structures. . . . Their primary job is to work on values, beliefs, and ideas of people who are going to be part of the change. . . . During periods of upheaval the [transforming leader described by James McGregor Burns] tapped the immediate needs and desires of constituencies and transformed them into a higher stage of aspiration and expectation that led to an effective action. . . . In the more complex and potent form of transformational leadership, a leader's power is based on an inherent sensitivity to followers' latent ideas, and an ability to raise them to higher goals. Interaction between leader and followers is mutually stimulating and elevating, and the change in motives and goals of both has a direct effect on social relations--and moral--ranging from the small and hardly noticed to the creative and historic. (p. 38)

Handy (1989a) states that leaders need to "live their vision" and Terry was consistent with his vision of the health network as a partnership. He said, "Basically I see myself as a switchboard operator making sure that the communication is going to the right area and I think what I've been doing is sharing my thoughts and ideas and being very honest with people," and, "In terms of the real way to get people to buy into things I think that if they get to own a piece of the action and their thoughts are in a document and they're sincere about them then I think they should be put in there."

Vision, Values, and Needs

Terry presented a vision of a health campus that represented a number of values that the other participant were likely to support, while at the same time having the potential to satisfy their basic needs. He sought to establish the climate which would allow each of the other participants to change or modify the vision in response to their own values and needs and their own view of the world. That the vision could be moulded to fit the other participants was Terry's view and this process was made possible by the context of collaboration and trust, two other values that the participants were likely to support. This cyclical process is illustrated in Figure 10.

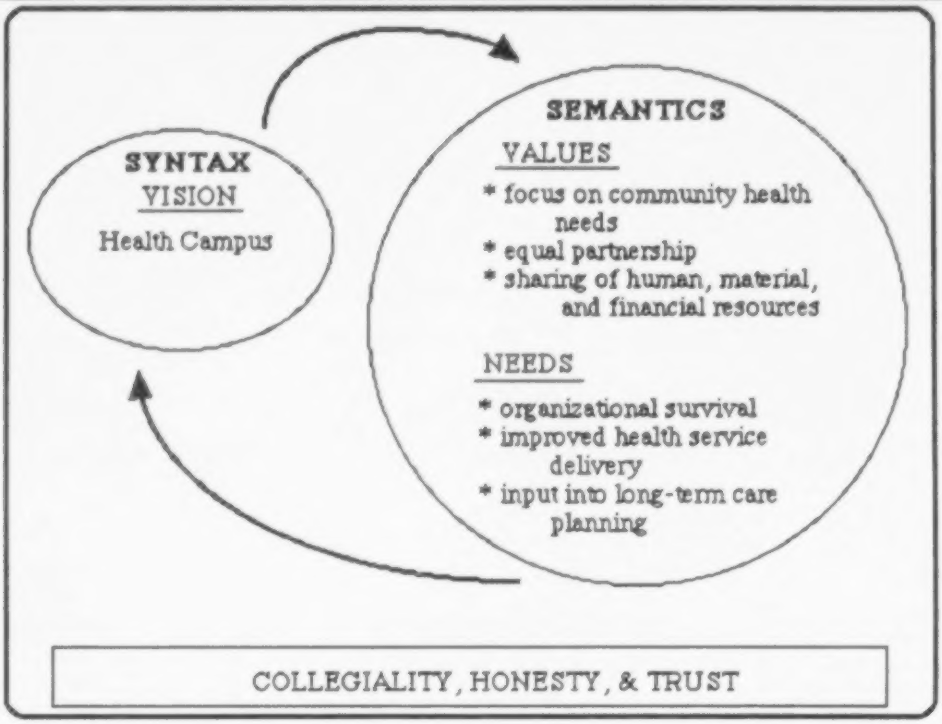
SEMANTICS
VALUES
* focus on community health needs
* equal partnership
* sharing of human, material, and financial resources
NEEDS
* organizational survival
* improved health service delivery
* input into long-term care planning
SYNTAX
VISION
Health Campus
COLLEGIALITY, HONESTY, & TRUST

Figure 10: The planning process.

Warren, Patrick, and Winifred each indicated they had differing basic needs and although the basic needs shown in Figure 10 do not apply to each participant, they were provided the potential to be taken into consideration in the planning process. As suggested by Pondy (1978) the syntax of leadership relates to the vision, whereas the meanings and values relate to the semantics of the leadership as Figure 10 illustrates. The planning process can therefore be considered as relating directly to the conceptual framework for the study and in that sense Figure 10 is an illustration of the interaction occurring between the syntax and semantics of leadership. In addition, the planning process involved observable activity by the participants and could thus be regarded as being the phonetics of the leadership. The relationship between the components of the conceptual framework, like language itself, is therefore not linear but is a complex interaction between the three parts.

The individuals' conceptions of the world and their place in it, and their individuals understandings about organizations were vital components of the semantics of leadership. The relationship between the semantics and syntax of the leadership, illustrated in Figure 11, are thus similar to, but not identical to those occurring in the planning process.

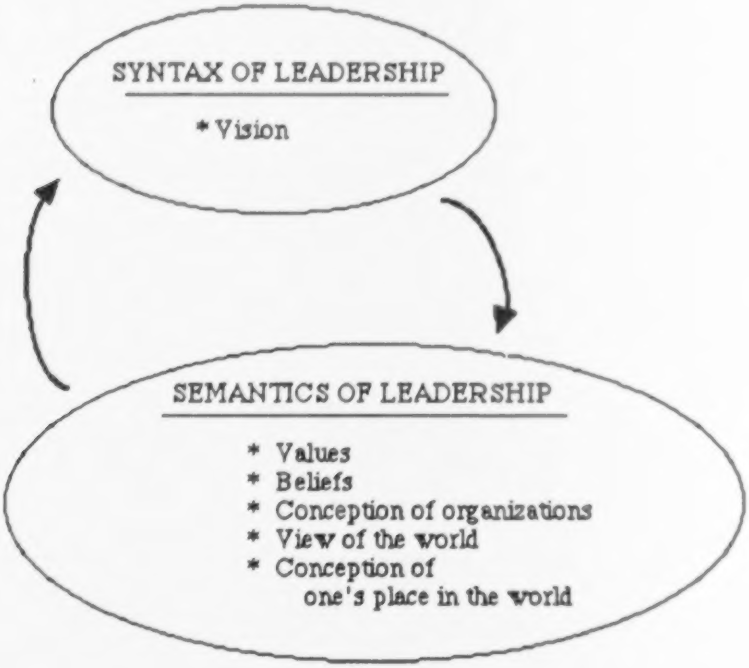
SYNTAX OF LEADERSHIP
* Vision
SEMANTICS OF LEADERSHIP
* Values
* Beliefs
* Conception of organizations
* View of the world
* Conception of one's place in the world

Figure 11: The syntax and semantics of leadership.

Because the planning process that was established was based on collegiality, honesty, and trust, these values not only became a part of the syntax, they assisted in allowing the participants' differing conceptions to be taken into account and to contribute to the moulding of the vision. The semantics of leadership include more than just the values and needs shown in Figure 10, however. The individuals' beliefs and understandings were also essentials of the semantics of leadership.

The leadership behaviour from the various participants can then be understood as an expression of each participant's view of the world and of their place in it. Those that saw themselves as managers contributed to the planning process as managers and those that saw themselves as visionaries contributed as visionaries.

Developing Relationships and Multiple Leaders

Terry exhibited institutional or transformational leadership in the way described by Keenhert & Lewis (1989) by using his personal standards and value systems to address the interpersonal connections and mutual obligations between the group members. He considered the interpersonal connection to be very important, saying that he "wanted to work on the relationships first." Donald referred to these relationships in saying,

> Dr. Smith,to my mind, is the "intellectual midwife" of the process because he has the most to lose and paradoxically the most to gain. . . . But the key point with him in the process was he really latched onto this program delivery idea and just, I think, worked with that concept and got that concept accepted into the document. . . . My perception of Dr. Smith is, again, he's like Terry and I think that's why it's worked. They're both visionaries, leaders . . .
>
> But that's why the leadership process was shared. I think the dynamics of the meetings that I attended it was Mr. Neville and if he wasn't consciously leading, wasn't saying much, it was Dr. Smith that took control of the day. . . . So I think there was a mutuality. Their personalities sort of matched quite well and that's why the leadership was shared and I don't think it could have been otherwise. I don't think one person could have dominated with both those persons there. I think Warren might have always been very quiet. . . . That's the sort of impression I have. He'd just go along with them.

Essential to Terry's openness was the importance that he placed on inviting all participants to be involved in meaningful participation in the planning process, referred to by Cronin (1989a) as "an engagement between partners and collaborators. . . . It is the two-way loyalty, the two-way communication, and the mutual engagement of leaders and 'led' that are crucial to leadership effectiveness" (xiii-xiv). Terry was constantly in communication with the other participants but none became as involved as Dr. Smith.

Donald was of the opinion that the creation of the partnership was an attempt by Terry to share the leadership and that Dr. Smith had accepted a leadership role. With regard to this sharing of leadership in the planning process Winifred said, "I would say Terry and Patrick, and then Warren, have sort of carried the ball, for sure." The way in which each of the individuals became involved appeared to be dependent on their personality, or the way they viewed the world and their place in it.

The individuals' realities were constructed through the filter of their values, beliefs, needs, and wants and the way these were applied to their situations determined their expectations of themselves and from others. Terry saw himself as a leader, but admitted to being a "terrible manager." Patrick Smith also saw himself as being a leader with a vision for an improved health-care system. Donald did not see himself as a leader, and his conception was that he was a manager, perhaps in the same way as Warren Pritchard. That Warren described himself as a hospital administrator, while Terry described himself as a chief executive officer may have been important. Terry certainly saw the difference in the terminology as being symbolic of a difference in the way they saw themselves.

Donald said of himself,

> What I say and do is to contribute and to draw out possible repercussions and implications. . . . I'm trying to keep things consistent with the health campus idea. I don't tend to have original ideas, that's not my strong point, but I can refine them and clarify them and assist in working towards them.

Despite these comments one member of the Timberwell Hospital staff described Donald as "having a wonderful vision." He was perceived by others as being a leader, and as Duke (1989) asserts, "Leadership is first and foremost, a perception invested with social meaning and value" (p. 348). If an individual is perceived to be a leader, or as Kouzes & Posner (1987) would say, "the one who goes first," then Donald was a leader. As McPherson et al. (1986) observe, "The definition of leadership and its proper exercise depends heavily upon perceptions of followers" (p. 245). From that perspective, Warren was also a leader because it was he who wanted Timberwell Hospital involved in the regionalization talks involving the other agencies and it was he that approached Terry about the two of them meeting to discuss regionalization.

The existence of multiple leaders reflects the thinking of Badarocco & Ellsworth (1989) who write that "in today's complex organizations one person can no longer be the sole repository of leadership" (p. 47). In the planning for the Richlands Health Network there were multiple leaders. Terry, Patrick, Donald, Bobby, and Warren all contributed to the leadership, as did Beryl and Winifred, but they often contributed in differing ways.

Leadership Forces and Leadership Behaviour

Perhaps what is important in the way people express their leadership in terms of their view of he world and their own place in it. Sergiovanni (1991) identifies a hierarchy of five leadership forces that may be used by school principals and the way that an individual expresses leadership may be explained in terms of the leadership force that is seen as being the appropriate one to use. The leadership forces are technical leadership, human leadership, educational leadership, symbolic leadership, and cultural leadership. These leadership forces may be applied to the current study because different individuals in the study expressed leadership in a way that may be understood in terms of Sergiovanni's (1991) forces. Leadership was understood by different participants in different ways.

The major difficulty with applying Sergiovanni's (1991) hierarchy of leadership forces is the existence of the educational force when "the principal [takes the form of a] knowledgeable colleague or leader of leaders who engages with teachers on an equal basis on matters of teaching and learning [with the aim of improving educational practice]"

(pp. 102-3). If this third level is thought of, in the same way, as being aimed at improving *administrative* practice the concept proves useful for the current study.

Rebore (1991) writes, "Administration is the process of managing human, financial, and managerial resources toward the fulfillment of a mission" (p. 9) and Hodge & Anthony (1991) refer to management involving planning and controlling; organizing, staffing, and directing; and decision making and influence. If administrative leadership is considered as facilitating the improvement of these activities, then Donald displayed such leadership. On numerous occasions Donald expressed frustration when he perceived that these management behaviours were not being practiced as effectively as he thought they should be and he sought to provide what he saw as the necessary structure for the planning and, later, the implementation process.

Donald played an important role in leading many of the meetings in which he was involved and was influential in the strategic planning process, preparing meeting agendas, setting goals, and leading in the creation of time-lines to focus their activities. He said, "Leadership implies vision, a concern with mission. It's broad and requires long-range thinking. Management is a day-to-day thing, oiling the springs," and in that regard Donald's contribution was important not only in the management of the planning process but in "leading the leaders" in seeking to improve the management of the planning process.

Sergiovanni (1991) describes the first three levels of his hierarchy as being necessary for a competent school, but for a school to be excellent, the leadership forces from the top two levels for the hierarchy are required. For the first three levels the values and beliefs that make up the school culture are implicit whereas with the expression of the symbolic and cultural leadership forces, those at the top of the hierarchy, the cultural values are made explicit.

Cultural and Symbolic Leadership Forces

Much of Terry's leadership behaviour involved the expression of the cultural and symbolic leadership forces. He encouraged Donald to take the role of leader in meetings, which was an expression of Terry's collaborative style and was an example of what Sergiovanni (1991) terms symbolic leadership. When expressed, this force is "emphasizing selective attention to the modelling of important goals and behaviours, and signalling to others what is important and valuable" (p. 103). In addition to modelling these values, Terry repeatedly verbally expressed these and other values essential to the creation of the type of health network he envisioned. Sergiovanni (1991) describes this as expressing the cultural force, when the leader "assumes the role of 'high priest,' seeking to define, strengthen, and articulate those enduring values, beliefs, and cultural strands that give the school its unique identity over time" (p. 104). This cultural leadership force seemed to be one that Terry was applying when he espoused his vision for the health network. However, in the event that he was described as a "high priest" Terry would assert that the health network as consisted of equal partners and if there were priests they all should be equally high.

Because the participants came from four different health agencies and were in the process of creating a new organization that was premised on equal partnership, Terry did not hold a position of privilege from which he could impose his views on others. Insofar as the Timberwell Hospital staff were concerned, the values of collegiality and teamwork that existed in the Senior Management Group were the same values that were influencing the Richlands Health Network, as it developed.

Leadership was shared within the Senior Management Group of Timberwell Hospital in a similar way to which it was shared within the health network. The difference between the two was that in the health network that the status differences were implicit understandings while in the Timberwell Hospital an administrative hierarchy was explicitly described in the Administrative Manual. In each case, however, the hierarchy was ignored.

The initial vision for the health network was presented by Terry as a draft document. As he said, "I'd stamped 'draft' and 'special purposes' all over it so they would see that I really mean that I wasn't saying this is the way we're going to do it, I'm just saying this may be the way it way it can be done." Patrick sought to modify the vision by introducing the concept of area-wide health programs and the concept fitted with the health campus idea because it promoted the same values of improved health-service delivery directed at the needs of the community.

When Patrick introduced the concept of health programs to the group he espoused and clarified the values and beliefs that constituted the basis for the health network culture and was thus using Sergiovanni's (1991) cultural leadership force. Patrick described his contribution by saying,

> Terry has the concept of the community campus, which is sort of opening the hospital to the community but that's not quite the concept of area-wide programming, but when I introduced that concept he picked up on it straight away. They way I look at it they're providing a lot of the leadership and drawing it together and operating the meetings as so on, and I've provided a little bit of the conceptual input to the way I see that we go about planning it in the future.

Donald and Terry were the "they" referred to by Patrick, above, as "providing a lot of the leadership."

By agreeing to include the concept of area-wide programs in the documentation for the health network the group put into practice the value of collaboration and sharing among the agencies. The meeting at which this occurred was held at Timberwell Hospital. The group had developed the understanding that the host administrator would act as chair, but as often happened, Donald played a leading role in the conduct of the meeting.

Like Donald, Warren did not see himself as a visionary. Warren showed leadership in initiating formal contacts between the two hospital administrations by ensuring that a representative from Timberwell be invited to the initial regionalization meetings held at High Valley. He saw that establishing an arrangement whereby Eaton and Timberwell hospitals were in the same region could be beneficial. When discussions of the two hospitals working together became more definite Warren readily accepted Terry's vision for the health campus and his contribution to the health network did not include the culture leadership discussed above.

Warren was placed in a difficult position in that his hospital was located within the boundary of the Marwell Health Unit and Dr. Baldwin resented him being involved with the Timberwell agencies. Like Patrick, Warren was repeatedly placed under pressure by Dr. Baldwin, and he often countered by showing symbolic leadership by reinforcing the values of sharing and partnership by stating that the group was "not looking at boundaries."

Of the other participants in the study Bobby and Dr. Simpson were also regarded as leaders by others. Bobby was an important inter-organizational communicator and was important in establishing personal linkages. One of the most important linkages that was created was that between Bobby and Beryl, and Beryl played a similar role, particularly in establishing the Association of Directors of Nursing. In these activities Bobby and Beryl were applying leadership as in Sergiovanni's (1991) human frame. Dr. Simpson's leadership role related mostly to his relationship with the other physicians and the way that he promoted the value of meeting the health needs in the community. In so doing he both espoused and modelled values important to the network and thus he exhibited leadership in both cultural and symbolic frames.

Leadership Without Bosses

The multiplicity of individuals showing leadership resulted in participants reporting that no single individual was dominant in leading the planning process. At the meeting attended by representatives from the Mental Health Department Patrick talked about the leadership in the organization, and related to what had occurred up to that point. "The leadership has been shared," he said. "This is leadership without bosses. There are no bosses. It's shared leadership." In supporting Patrick,Warren went on and said, "We don't have one leader. That's been our practice all along. Not one leader. We move meetings and we move chairs." When she was asked about the leadership in the organization Winifred nominated Patrick as the most important, but said that Terry and Warren had also shown leadership. Winifred also paid tribute to Bobby's efforts.

Patrick had first referred to the existence of "leadership without bosses" in an interview when he expressed concern as to how the leadership would function when they came to the allocation of resources. He said,

> So it's great when you have that kind of cooperation. I don't know how the leadership will work . . . if you have to choose a chairman. Right now they're just rotating and everybody's putting the time and energy in and it's working so far. And the concept of leadership where nobody's the boss, I'm not exactly sure how that works out. So there's really a lot of unknowns. . . . It requires goodwill and if you get some player that won't fly, you have no mechanism to bring about compliance.

There were in Patrick's comments an indication that the issues of power and authority remained a part of his thinking. Warren's linkage of leadership to the chairing of meetings also suggested that he had retained some basic beliefs about leadership having an association with position, in this case the chairpersonship of a meeting. These comments by Patrick and Warren do pose questions as to the degree that the paradigm shift, where thinking had to move from a focus on facilities to a focus on cooperation between facilities, referred to by the Minister of Health had taken place in actuality and the extent to which the values of collaboration and and partnership would over-ride the more traditional, hierarchical and bureaucratic conceptions of organizations.

As in Wilson's (1992) study, when "hierarchical rule had prevailed when a deficit was anticipated" (pp. 5-6), the collegiality could collapse and return to the separate bureaucracies as the result of disagreement about the distribution of resources. Such discussions would likely be a test of the extent to which the participants had completed the process of "cognitive transformation" referred to by Schein (1985) and converted the values of sharing and equal partnership "into a belief and, ultimately, an assumption" (p. 16). Schein (1985) goes on,

> Such values will predict much of the behaviour that can be observed at the artifactual level. But if those values are not based on prior cultural learning, they may also come to be seen only as what Argyris & Schön (1978) have called "espoused values," which predict well enough what people will *say* in a variety of situations but which may be out of line with what they will actually *do* in situations where those values should be operating. (p. 17)

As Patrick said on one occasion, "This has been easy so far. When we get to dividing up the savings it won't be so easy."

The participants had each indicated that they had at least accepted those values by taking part in the planning of their network, while others outside the network had been reluctant or unwilling to embark on such a paradigm shift. The traditional thinking of health agencies as separate bureaucracies and of control through hierarchies retained dominance in many circumstances, to the extent that in some locations administrators could not even agree to talk to each other about regionalization. Terry recalled a conversation that he had had with another health administrator that showed the differences it attitude. He said,

> I've been letting [other health administrators] know what we're doing and that's creating the fear and mistrust because one of them said, "When are you going to take us over next?" And it wasn't in a nice way. And I said, "Well nobody's taking anybody over." She just couldn't grasp the view. She said, "Well, it's really a takeover." And she said, "Well, I'm a person that's been in management for a long time and I say that nobody can work in a partnership and there has to be one boss and that's it. And you've got to be in control of everything."

The members of the Richlands Health Network had overridden concerns of this nature. They had initially come together to address their individual needs and had engaged in a mutual dialogue in defining and refining the way in which their agencies would be able to work together. The reliance on organizational structures that were based upon hierarchical relationships between its members had been replaced with a collaborative relationship which made allowance for and accommodated the differing world views the participants.

Conclusion

The Richlands Health Network was based on the vision of a health campus developed by Terry Neville. The vision contained ideas that were not only in sympathy with the vision of the Minister of Health, the ideas that were expressed in the health campus concept were representative of thinking expressed in current literature and with the philosophy behind the operation of health units. The vision for the health network was an expression of values that each of the participants could support and offered initial attraction because it promised to address their individual needs. In addition, the planning for the health network was meaningful for the participants because each became a part of the process and was able, in some way, to contribute to the leadership. The participants' differing world views were accommodated in the planning process and leadership was expressed by the each of them in a way that appeared to be compatible with each individual's world view.

The leadership behaviour was analyzed using the conceptual framework developed from the metaphor of leadership as language, developed by Pondy (1978). The conceptual framework consisted of three components, the semantics the syntax, and the phonetics and the leadership was analyzed in those terms. The interaction between the vision, the cultural values, and the actions of the participants illustrated the complex interactive nature of the components of this conceptual framework.

The vision and the common understandings that developed were considered to form the syntax of the leadership and the values, needs, and beliefs of the participants were considered to be the semantics of the leadership. A common set of values and meanings about what the group was attempting developed as the case proceeded. The participants' differing understandings and the meanings that they made of their organizations were brought into their interactions and a synthesis of their beliefs developed. A culture of collaboration and sharing developed.

These values and beliefs were expressed as the vision for the health network that developed, as was described in this chapter, and by the symbols that were considered in Chapter 6. The observable behaviour of the participants was the third component of the conceptual framework, the phonetics of leadership. In addressing this third component, the leadership roles played by the various participants in the developing of a shared meaning were considered and analyzed. No one individual was seen as having right of way, but different individuals expressed leadership in the way that each saw as appropriate.

This observable behaviour can be more easily understood when considered in terms of the relationship between the meanings held by the participants and the way they were connected to their actions. The managerial approach to leadership shown by Warren and Donald can be understood in terms of their mechanical conceptions of organizations.

In a similar way, Patrick understood the Timberwell Health Unit as having a quite rigid structural form, but he did not see that that particular structure was the way things had to be. He was quite prepared to change the structure of the Timberwell Health Unit if such a restructuring could help the mission of promoting community health be more easily achieved. This understanding of organizations was evident in the way in which Patrick described the developing health network in structural terms. At the same time, Patrick was attempting to transform the conception of the network held by the other participants from one of a health campus consisting of a number of health agencies to one in which health programs were central, and the agencies existed only to implement the programs. Like Terry, Patrick also conceived an organization as existing to express particular values.

The meanings underlying Terry's conception of organizations, like those of the other participants, were illustrated by the way in which he conceived of leadership and the way in which he expressed leadership. This conception of organizations being values-based were reflected in Terry's and Patrick's leadership which was based on values such as sharing, equal partnership, and meeting community health needs. The promotion of such values resulted in both Patrick and Terry seeing themselves as visionaries and they expressed their leadership in a visionary manner.

CHAPTER EIGHT

Themes and Implications

Introduction

This chapter provides an overview of the study. In the first part of the chapter the themes that emerged from the study are described and the research problem and focusing questions are addressed within this framework. The conclusions from the study are presented and the chapter concludes with a discussion of the implications for administrators arising from the study and proposals for further research.

The Emergent Themes

The purpose of the research was to investigate the operation of leadership and the meanings attributed to leadership activity by the various participants. The intention of the study was to increase the understanding of the leadership phenomenon through interpretations of the events. The study was of a single case and the individuals and events that occurred comprised a unique situation and as a result the findings of the research need to be regarded with some caution. A consideration of the themes that emerged from the study, however, promises to be fruitful in the pursuit of this increased understanding.

In all, 14 emergent themes--the main ideas coming from the data--were identified and collapsed into four groups, with the themes in each group having a degree of commonality. The groups were labelled Value Themes, Process Themes, Leadership Themes, and Conventional-thinking Themes.

The themes that were classified as Value Themes included those of honesty and trust, group culture, and sharing. The themes of participation, partnership, and the program approach were classified as Process Themes and the themes of leadership, vision, and teaching were classified as Leadership Themes. The Conventional-thinking Theme group consisted of the themes of boundaries and territorialism, administrator/physician conflict, the emphasis on hierarchies, and business thinking.

The arranging of the themes into the groups was to a degree simplistic as overlap existed between the groups: particular aspects of some themes meant that many of them could be considered as fitting into more than one group. The groups of themes were also classified into two sets which worked against each other. The competition between the themes in the two groups created difficulty in the data analysis because, initially, I could not see how themes pulling in opposite directions could explain the events of the case.

The Value Themes, Process Themes, and Leadership Themes were supportive of each other and together representative of the forces that drew the health network together and are termed centripetal forces. The other group of themes, labelled Conventional-thinking Themes, represented long-held assumptions and beliefs about the organizations described by Schein (1985) as "learned responses to a group's problems of survival in its external environment and its problems of internal integration" (p. 6).

The themes in this group tended to contradict many of the processes involved in the planning of the health network and the forces emanating from them were termed centrifugal forces. These forces worked against the creation of the health network and if the effort to create the health network failed would be expected to dominate in the retention of a status-quo situation for the health agencies in the study. Leadership was required to facilitate development of processes which would achieve these goals. The relationships between the themes and groups of themes is illustrated in Figure 12.

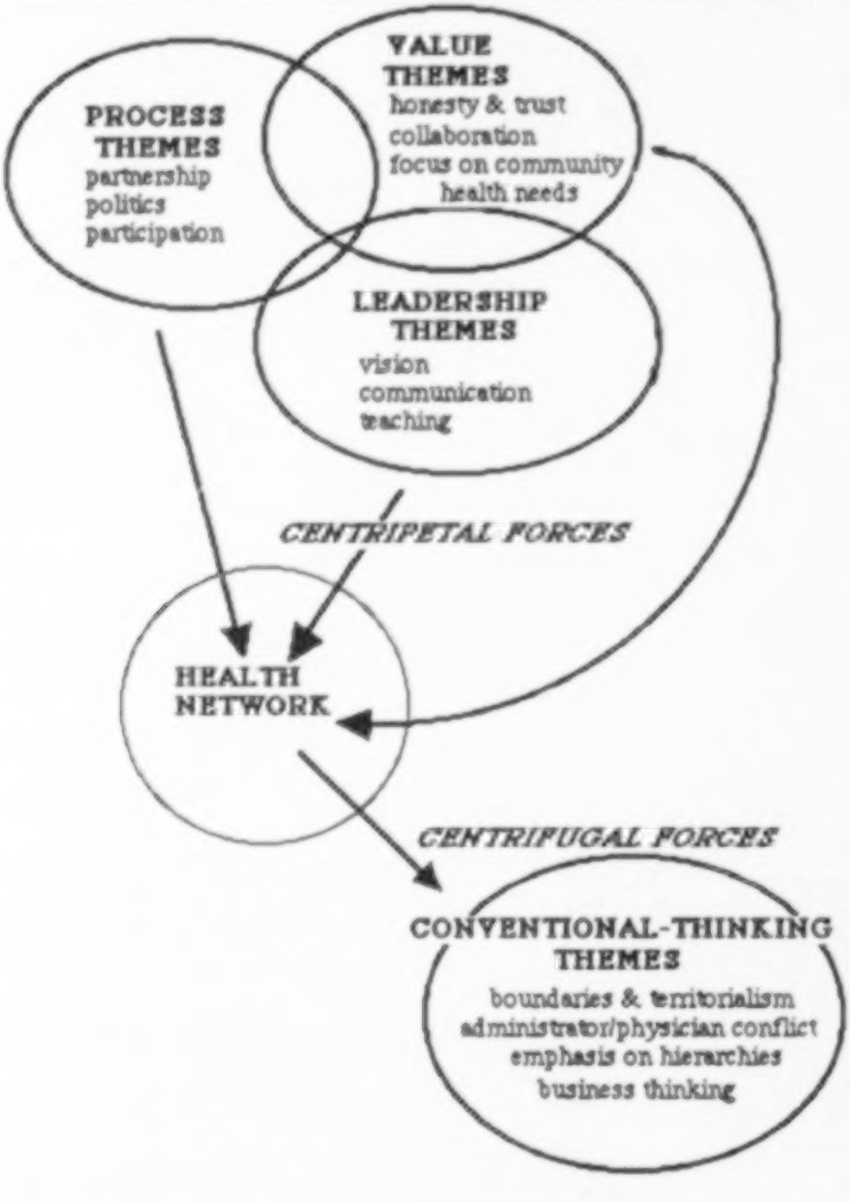
VALUE THEMES
honesty & trust
collaboration
focus on community health needs
PROCESS THEMES
partnership
politics
participation
LEADERSHIP THEMES
vision
communication
teaching
CENTRIPETAL FORCES
HEALTH NETWORK
CENTRIFUGAL FORCES
CONVENTIONAL-THINKING THEMES
boundaries & territorialism
administrator/physician conflict
emphasis on hierarchies
business thinking

Figure 12: Thematic forces as influences on the health network.

Terry was cognizant of the need to overcome the centrifugal forces, saying during one interview,

> I think that we all have a few problems. Some of it is we have to get away from our traditional mind sets in terms of the way we function now. Another problem is that we have to get comfortable and used to working with each other and develop some trust.

Investigating Leadership and Associated Meanings

For the creation of the health network to occur the centripetal forces had to be more powerful than the centrifugal forces to allow the commitment to proceed to develop in the participants from each of the agencies. Schein (1985) terms the overcoming of previously held beliefs and assumptions "unfreezing," and this was achieved because the participants developed a sense of ownership and came to regard the creation of the health network as having intrinsic worth. This belief in the intrinsic worth of the health network developed to the stage that when the Minister of Health postponed the regionalization process the immediate reaction from Terry and Patrick was that they should proceed despite the announcement. Warren's valuing of the network was illustrated when on numerous occasions he had said that creating the network was something that "should have been done years ago."

The creation of powerful centripetal forces for the network occurred because the synergy described by Covey (1991) was created within the network group. This synergy developed because the values underpinning the creation of the health network were expressed in both the processes and intended outcomes of planning the network.

The values could be supported by the participants and the "unfreezing" of traditionally held beliefs was thus made possible. The Process Themes and the Value Themes were to a large extent supported by the Leadership Themes and the three clusters of themes combined to provide sufficient force to hold the planning process together. Due to this supporting function and because leadership was the focus of this study, the Leadership Themes are considered first.

The Leadership Themes. The Leadership Themes were vision, communication, and teaching. Terry presented his vision of a health campus as the vision for the health network and he spoke of this vision again and again. That the Minister of Health's vision of a regionalized health system and the health-campus concept were so similar greatly improved the appeal of Terry's vision, but as was discussed in previous chapters, he did not present his view as the only alternative. Terry desired to find the way in concert with the others and the promotion of this joint finding-of-the-way was interpreted by me to be a sharing of leadership.

Terry expressed leadership in "showing a way to go," but in so doing repeatedly invited others to contribute, saying that he wanted the "creative juices to flow." He wanted all participants to contribute to the leadership by adding to his vision, to suggest modifications in direction or approach so that the vision could develop and improve. This process is what Barth (1993) describes as occurring when a group combines to

> grow a vision. . . . Through this process the group mines the gold nuggets in the gravel and extracts not their commonalities but the most promising ideas. . . . If the process is inclusive and genuine, the vision is likely to be embracing and honest. (p. 10)

Terry expounded his vision for the health campus on numerous occasions and at the same time urged the group to be proactive in improving the idea, saying that his was not the best or the only way. On one occasion he said to me, "[I] just remember my principles and my working by example. I must temper myself sometimes, as a good leader. When people get involved they all should have some input."

By being in almost constant communication with the other participants, Terry provided them the opportunity for input. He met informally with other members of the Timberwell Senior Management Group usually several times a day and was in continuous telephone contact not only with other participants in the health network, but with others in the health system with whom he desired to share and promote what he began calling "our vision," or from whom he was seeking information.

Although Terry was an expert communicator there was the clear understanding that he should not be the only communicator. Patrick and Warren contacted Terry probably as often as he made contact with them. Ideas were constantly aired and shared, and no idea was rejected until it had been considered by the group as a whole. Even then, none was rejected unless it was rejected unanimously. The communication was clearly of importance in sharing and building the synergy and sense of community that the health network developed.

Communications involving Winifred were much less frequent than those between the other chief administrators, however. That Winifred was the only woman who held a chief administrator role may well have been important, and that she was administrator of a facility of relatively low status could also have been significant. Some feminists would argue that because health administration has traditionally been a male-dominated profession and because Winifred's facility was of relatively low status it could be expected that the male chief executives would pay her little regard. The influence of gender, however, was not pursued in the current study.

In addition to the possible effect of gender and status, Winifred's involvement in the health network may have been influenced by the fact that her facility was different from the other three in that it did not provide services to the general community in the sense that the Nursing Home catered almost exclusively for the aged. Winifred told me that she had ensured that she had become involved in the health network so that she could be sure that the Timberwell Nursing Home had an influence on future planning for long-term care in the area. She may have had less reason for commitment to the health network than other participants. As well, there was no perceived threat to the survival of her agency. Timberwell Nursing Home was a part of the province-wide

Western Province Long-Term Care Organization and was the only agency providing long-term care in the Timberwell/Eaton area.

While these issues may have all been factors in Winifred's relatively low level of involvement in the communications, Terry and Winifred did not have a positive personal relationship, which was of concern to Bobby and Donald when they were discussing the making of the initial formal approach to her about becoming a part of the network. Certainly the reciprocal communications between Terry and Warren, and between Terry and Patrick, were not reflected in those between Terry and Winifred even though both made the apparent attempt to steer away from their personal differences. If Patrick or Warren wanted to discuss an issue or present a proposal other than at one of the formally convened meetings, they invariably called Terry, rarely calling each other or someone else. Patrick was in contact with Dr. Baldwin a number of times early in the case, but after Patrick became committed to joining into the health network the interactions between the two ceased to be positive. Winifred tended to communicate with others in the network to only to a limited degree, although in the early stages of planning Donald was in frequent contact with her.

Terry was the focus of much of the intra-group communication and the cool personal relations between Winifred and Terry may have been important in limiting communications between the two. Terry's importance to the communications within the network may well have been a major contributor to the smaller role Winifred played in the communications with the other participants. Terry was conscious of his communication-facilitation role, saying during one interview, "Basically I see myself as a switchboard operator making sure that the communication is going to the right area and I think what I've been doing is sharing my thoughts and ideas and being very honest with people."

Important communications also occurred between other participants, particularly involving Bobby, who was in frequent communication with Beryl and Janet, who held positions equivalent to Bobby at Eaton Hospital and Timberwell Health Unit respectively. Bobby also enjoyed a cooperative and effective working relationship with Donald and the two had many discussions on matters pertaining to the health network. Like Bobby, Donald was also important in communications, working closely with both Warren and Patrick in the early stages of the network planning.

Donald's involvement with the planning document drew on his highly developed strategic-planning skills and in regard to the preparation of the plan and its implementation of the planning process he hoped to play a teaching role by exhibiting modelling behaviour. Teaching was the third of the leadership themes.

This theme had first begun to emerge with Terry expressing the view that he felt that Warren and Patrick were "old fashioned" managers and he was keen to show them a more participative style. He said, "I think they'd really surprise themselves if they backed off a bit from their staffs." Terry did not claim that he would *always* be the teacher, however. He encouraged Donald and Patrick to work together on preparing the proposal document because he felt that Donald had a high level of skill with such tasks and that they could all learn from Patrick about health-program planning. Terry was always ready to "sharpen the saw" (Covey, 1991) by improving his performance by learning something new. He was interested in having this study done because he was anxious to learn from what might be found.

In so far as the Leadership Themes were concerned, Terry's intention from the beginning was to embark upon a collaborative exercise in which the leadership was shared--a reflection of the way in which he operated with the other members of the Timberwell Hospital Senior Management Group. Although the locus of leadership appeared to lie with Terry, the participants regarded the planning process as a shared-leadership exercise and no single individual, including Terry, showed the inclination to claim personal credit for what was achieved. To the contrary, on different occasions participants gave credit to each other for making a worthwhile suggestion. A strong feeling of collaboration and joint ownership did develop and as Terry commented to me after a telephone conversation with Dr. Baldwin, "He likes *our* model," (emphasis added). I considered the comment important because it was made in private and there was no suggestion that the remark was made for the symbolic value or was made for the benefit of other participants.

The Process Themes. The collegiality and sharing of leadership referred to above was clearly reflected in participation and partnership, two of the Process Themes. The third theme, politics, was one where Terry played a most significant, almost dominant role, due partly to his skill as a political operator and partly because he had established an extensive networking system through which much of his political activity external to the health network membership could be funnelled. Even with his network, however, Terry expressed a willingness to include other network members, saying, in conversation with Donald, "I'll have to get Patrick into my network. I'm [frustrated]--it took me ten years to set it up, but if they are to be equal partners they have to have equal partners. It's a bit of a threat to me." These comments show the tight linkage between the internal politics and the concept of partnership, a second of the Process Themes.

As was discussed in Chapter 6, the health system was thrown into an environment of uncertainty and mistrust following the Minister of Health announcing the regionalization policy and Terry saw that the only way that he could interest others in joining him in creating a health region would be if his approaches were made in a non-threatening manner. He expressed a deeper commitment to the partnership than the need to meet these political demands, however. Early in July, during the initial stages of the study, Terry said,

> [If we establish] this whole atmosphere of partnerships and everything else the strong will have to support the weak and build up their ability to survive, if there's a reason for them to survive. If there's a reason to survive--that's the big question. And the only way that you can answer that is to work together and see if you can make certain things work.

The theme of "equal partnership" was something that Terry constantly promoted as an integral part of the vision for their health network and all participants came to accept the partnership as being a basis for their working together. Closely related to the idea of partnership is that of participation, although the two terms are not synonymous. Terry saw participation in the planning as important because it would promote ownership in the process and its outcomes. Terry and Donald had talked on a number of occasions of involving Winifred as much as possible, with the aim of gaining her commitment to the network by developing her sense of ownership in it. Terry said,

> What I'm trying to push is the ownership aspect. So people have talked. I want everyone to talk. . . . So if we're really going to be a consensus-based group, and have equal partnerships and everything, they're going to have to have their say.

Terry's referral to communication, one of the Leadership Themes, is an illustration of the interrelatedness of the themes, and the concepts of ownership, partnership, and politics that have been discussed here are linked not only to the Leadership Themes grouping, but to the Values Themes grouping. A common factor with the successful addressing of these three issues is the the theme of honesty and trust. If honesty and trust had not been established, no meaningful dialogue or partnership would have occurred. The Process Themes were largely facilitated by the Leadership Themes, but they expressed the Values Themes.

The Value Themes. The health network was based on an atmosphere of honesty and trust, and along with this theme the themes of collaboration and focus on the health needs of the community comprised the Value Themes. The values that comprise this thematic grouping were expressed in the planning process and the Process Themes addressed above. The leadership activity expressed the values and promoted them as the basis for the vision and the creation of the health network, but in addition to linking these two groups of themes, the leadership activity was also directed at the themes that have been termed Conventional-thinking Themes. These themes created centrifugal forces which made the creation of the health network more difficult and, once the network began to take shape, threatened to pull it apart.

The Conventional-thinking Themes. Four themes, boundaries and territorialism, administrator/physician conflict, emphasis on hierarchies, and business thinking were identified as comprising the Conventional-thinking Themes. These themes had to be neutralized, modified, or in some way overcome if their centrifugal forces were to be prevented from pulling the health network apart.

The concern with boundaries was a built-in concern of those in health administration in Western Province. The governance of the agencies was based on municipal representation and as such political boundaries had a significant part to play. The governance, funding and operation of the various agencies had ensured that traditionally the agencies had operated independently and, by implication, had been regarded as being in an almost competitive relationship with one other.

The Minister of Health suggested that multi-sector health regions be formed, describing the concept as a "paradigm shift." The concept of regionalization required a new way of thinking because the various health agencies were no longer to be considered as separate businesses and the various sectors of the health system were no longer to be regarded as separate entities. The boundaries between health agencies and between the health sectors had to be disregarded.

At the beginning the boundary-thinking was retained. The Minister of Health had called for the definition of area planning networks, which was taken by the participants in the study to mean a geographical area. At the initial planning meeting to discuss the proposal for their region that would be presented at the October 6 meeting with the officials from Provincial Health the group members resolved to include a map of the proposed region, based on the assumption that they were expected to define their region in terms of a boundary. However, after the postponement of the October 6 meeting and the decision by the group to proceed on their own the map and the boundaries were abandoned.

The focus for the group became area-wide health programs and, "We're not looking at boundaries," was a commonly heard comment. By ignoring the boundaries there was an attempt to create the "win-win" situation referred to by Covey (1991) by removing the threat of boundary incursion or take-over. The choice of the names for the network, both the original "Pioneer Country" and the finally agreed-upon "Richlands," involved the conscious decision to not include the names of towns of political jurisdictions that could be interpreted as meaning a specific location and by imply the exclusion of agencies that did not fall within certain boundaries.

Like the boundaries and territorialism theme, the emphasis on hierarchy was neutralized largely through the symbolism of the vocabulary that was used. Each of the participants understood that the member organizations were regarded as having differing status levels. For a network to be a possibility the understanding had to develop that that its creation would not mean the take-over or the absorption of the smaller by the larger.

Whereas the formation of the network involved ignoring the boundaries the traditional thinking in terms of bureaucratic control and the importance of hierarchies that had been prevalent in the field of health administration had to be reversed. Regarding the differing status positions as being representative of a hierarchical position ran counter to the principles of collaboration and sharing behind the health network. The matter was addressed by describing the relationship between the group members as not simply a partnership, but an equal partnership, a largely symbolic action which was reinforced by both the actions and words of the participants. An exchange between Winifred and Terry at one of the meetings provides an example:

Terry: We can't be an institution without a vision. We have got to work out what we can do together.

Winifred: That's why I came today, I want to be involved.

Terry: You are a full partner, equal to us. We should set a date for a workshop retreat and arrange a facilitator.

The overcoming of what Schein (1985) terms a "pecking order" occurred, in the eyes of Patrick and Warren at least, when they described how their group had functioned to the Provincial Health people that attended the group's October 6 meeting. Patrick said, "The leadership has been shared. This is leadership without bosses. There are no bosses. It's shared leadership," and Warren said, "We don't have one leader. That's been our practice all along. Not one leader. We move meetings and we move chairs."

The implied equation of leadership and chairmanship in Warren's statement was an indication that thinking in terms of hierarchies and position had perhaps not been totally overcome, but had been absorbed into the health-network thinking. If this absorption had occurred it would have been similar to what occurred with the third Conventional-thinking Theme, business thinking, which was modified and absorbed into the health network.

Traditionally the various health agencies had been funded and operated separately with minimal interaction. The agencies had operated as separate, independent businesses and the health network required a change in this thinking. The diagram showing the relationship between the various providers in Patrick's health program document accepted the business functions of the agencies, but termed them "support services" and they were related to the health programs rather than the individual agencies. This new way of regarding the business functions was accepted as a principle of the health network and some of the most difficult negotiations occurred between the staffs from the two hospitals as they addressed the problem of rationalizing these services.

Difficulties regarding staff fears over job security and the prospect of union involvement arose and would need to be overcome before progress was made. The group agreed that the key way of overcoming problems of job security was to consider staff reductions only on the basis of staff attrition and that they would not embark in staff cut backs. All agreed that the staff members who had the potential to be affected would need to be involved in the formulation of the strategies for the rationalization of services. This process of rationalization through attrition had begun with the resignation of the Finance Directors of both the Timberwell Health Unit and the Timberwell Hospital, and their replacement by one person who would do both jobs. In addition, the two agencies would use the one computerized financial system. The traditional business thinking was thus modified, because the infrastructure for financial management became shared between the two facilities, and absorbed into the health network, but still remained as having the potential of, if not destroying the network, then at least to make its full implementation difficult unless the staff concerns could be overcome. The fourth of the Conventional-Thinking Themes, administrator/physician conflict, had similar potential.

The difficulties in relationship between hospital administrators and physicians are referred to in the literature as a long-time health-administration issue. Terry was of the view that without the support of the physicians their plans for a health network would be fruitless. He said of physicians,

> Technically they're brilliant, but politically and from an economic point of view, a lot of them are weak in those areas. I think they can be stronger if people who are strong in those areas share some information with them. Those things have never been important to them through from medical school but they're sure important in surviving in the . . . system, especially if they're associated with hospitals.

Terry set out to create a coalition with the physicians, and was successful in gaining the support of Dr. Simpson, the Medical Director at Timberwell Hospital, and others such as Dr. Briggs and Dr. Wyndham, who appeared to be important as leaders among the physicians. Warren was concerned with the opposition that the physicians at Eaton Hospital were voicing about the health-network proposals and enlisted the help of Dr. Simpson and Dr. Briggs in overcoming that opposition. The implementation of plans for the health network had only just begun when the study ended and the centrifugal force of physician opposition retained the potential to pull the coalition apart and make the operation of the health network a vain hope. As was discussed above, the implementation of the plans for the health network would be the subject of another study and the effect of the centrifugal forces in the longer term are not considered here.

Implications for Practice

In addition to the limitations and delimitations, as described in Chapter 1, the study had the additional limitation of having been conducted from my personal perspective, both as an individual and as an Australian school teacher with limited prior knowledge of health administration in general and the Canadian health system in particular. In addition, I was closely involved with the participants over a four-month period and they acknowledged that my presence in conducting the study influenced their behaviour. While cognizance must be paid to these issues, particularly with the limited generalizability of the study findings, a number of implications for administrative practice arise from the study.

Whereas the study was of health administrators and it may have implications for administrative practice for health administrators, it may also have implication for administrators in other disciplines. As an educational administrator I gained insights from this study and found it most meaningful.

A common thread that has run through the thinking and writing on leadership from many years has been the relationship between leaders and followers. The length of time that this has been an issue is illustrated by Bahr Bleedorn (1988, p. 28), who quotes a Chinese philosopher's comment that is several thousand years old:

A leader is best
When people barely know that he exists.
Of a good leader, who talks little,
When his work is done, his aim fulfilled
They will say, "We did this ourselves."
Lao-Tsu.

There is debate in the literature as to whether or not such leadership should be considered manipulative. I would argue that if the leader in question was truly a facilitator, a true sharer of leadership, and the "aim fulfilled" had genuinely come from the group, then the leadership would not be manipulative. If administrators desire to truly involve all of the members of the organization with the aim of maximizing the benefits that would derive from their cumulative knowledge and experience of the group, then they may well learn from the study of the Richlands Health Network. The implications from this study are discussed in terms of the central importance of communication, the differing world views of organizational members, the avoidance of ego-involvement and the need to avoid any emphasis on hierarchies, and accepting that different people have different conceptions of leadership.

Multi-directional Communication

Of absolute centrality in leadership is communication. In the study of the Richlands Health Network it was the communication between the various participants that made the planning and the creation of the health network a possibility. For a group to be effective a common understanding of what it is and what it is happening must be held by its members. As underlined by Pondy (1978), on whose ideas the conceptual framework for the study was based, effective communication must occur. Of great importamce is that the organizational administrator play a leadership role in ensuring that communication channels between group members are open and used. This leadership role requires the facilitation of communication, and as was shown in the study reported here, the communication must be multi-directional and the administrator's prime function is to facilitate the process, allowing common understandings to develop. Group members need to develop an understanding of their own and others' views of the world and their place in it.

Differing World Views

The argument has been presented here that the most important issue when considering organizations is that they are made up of people and to a large degree the organizations are what the people in them perceive them to be. Implied from the study is that the different world views of group members need to be taken into account. No individual can impose a world view on another because an individual's world view revolves around the values, beliefs, and assumptions that are held.

The use of the conceptual framework developed from Pondy (1978) helped in the understanding of the relationship between beliefs and values, the way in which they are expressed, and people's observable actions. The metaphor of leadership as language refers to them respectively as the semantics, the syntax, and the phonetics of leadership. The implication for administrators is that the attempt needs to be made to understand the relationships between these aspects of leadership and, if leadership is to be shared, then all group members need to be given the opportunity to articulate their own meanings and values so that they can develop an understanding of what they are doing.

The inclusion of all group members in such an interaction may well prove difficult, especially in organizations which have been traditionally hierarchical in nature and when particular facilities such as schools are considered to be integral parts of a much larger bureaucracy. A fixation with hierarchical position may mean that some organizational members see the involvement of individuals from low levels in the hierarchy as inappropriate. Long-held assumptions may need to be challenged. From the perspective of an administrator, the first assumption requiring to be challenged may be that the holding of a senior position is equated with superior knowledge and wisdom and that the ideas from those in more senior positions should hold sway. Those in such positions may need to overcome an ego-involvement with inter-personal interactions.

Overcoming Ego-involvement and Ignoring Organizational Hierarchy.

An important implication deriving from this study is that for an administrator to share leadership any ego-involvement needs to be put aside. If a true sharing of leadership is to occur, no participant should have what Foster (1986) describes as "right of way." One aspect of the sharing of leadership that occurred in the study of the Richlands Health Network was that Terry did not have an ego-attachment to his vision of a health network. He was both keen to teach others and to learn from them. When Patrick suggested that the concept of the health network be focussed on health programs--an important variation on Terry's health campus concept--Terry did not feel threatened. He was more than happy to accept the idea. Further, Terry and the other participants were willing to learn from Patrick and were keen that both themselves and the health network would benefit from his expertise on health programs.

School administrators, and administrators of similar organizations, are not in the position that those in the Richlands Health Network were. For the most part they belonged to different organizations, and the only way in which ego-involvement was a factor was with regard to the relative status of each organization and the organization's chief executive. In that sense there may have been considered a hierarchy of importance based upon the relative status of individuals' positions as chief executives of the various organizations. A school principal has a rank that has been defined by the bureaucracy within which a school is found, but ego-involvement related to the different status-levels allocated to those involved has no place in the organization if shared leadership and true collaboration are to occur. Different people in an organization may be allocated different functions--one being a mathematics teacher, another a pre-primary teacher, and another an administrator--but if principals and other administrators, hospital executives, or administrators from other organizations are to encourage and develop leadership across their organizations then the expression of leadership positions by others must not be seen as a threat to the individuals' egos or their positions in the organization.

In the Richlands Health Network, the most influential person in leading the group through the process of planning the creation of the network was Donald, who was not only not a chief executive, but was the most junior of all those from the Timberwell Hospital that were involved, and was actually only a part-time employee. He became a leader in the process because of the personal qualities and expertise that he possessed. The administrator who wishes to share leadership can expect to need to seek the involvement of others in the organization no matter what their status in it. Implicit in this is a facilitating role for the administrator.

Centripetal Forces. From the data in the current study emerged the process, value, and leadership themes. While they were in synchrony they created the centripetal forces that held the health network together, promoting a sense of unity, ownership, and commitment. If these themes are able to emerge from the interactions between group members they can assist in "unfreezing" aspects of an organizational culture that might inhibit a sharing of leadership--and a key inhibitor is an emphasis on hierarchy in an organization.

Agreements about the processes, values, and leadership themes should emerge from group interactions. If these are imposed, the group members are unlikely to feel a sense of ownership or them and, unless the circumstances are quite fortuitous, they will not be agreed upon by all of the group members. Without that agreement they are likely to act as centrifugal forces and work as destabilizing factors. The administrator would need to play a facilitating role to ensure that ideas are expressed and shared and common understandings are developed.

That administrators may find themselves in bureaucratic organizations need not necessarily mean that the "strictures" referred to by Angus (1989) or the "domination" referred to by Noddings (1990) must occur. As appeared from the current study, the sharing of leadership and the development of common understandings and agreement on processes, values, and leadership can prevent such situations from occurring.

This concept is particularly meaningful for me, as a school principal. This study has helped me understand that difficulties that I have experienced in in schools in the past have occurred because the differing values, beliefs, and understandings about the processes occurring in the schools had not been enunciated, clarified, and mutually understood by those involved.

The current study found that a relatively unified group developed because each of the participants found the opportunity to contribute to the definition of group values and processes through expressing their own leadership behaviour in the manner they saw as appropriate. How each individual perceives their contribution, particularly with regard to their leadership behaviour, depends upon their world view.

Different Conceptions of Leadership.

The study reported here is that leadership means different things to different people and various individuals expressed leadership in that context. In a similar way in which people are likely to have differing conceptions of organizations, they are likely to have differing conceptions of their place in them. The implication from this is that administrators should not be expecting group members to express their leadership in any particular way. If individuals are invited to contribute to the leadership within an organization they must be given the opportunity to express that leadership in the manner that they perceive as being most appropriate.

The part for the administrator is again to be the facilitator. The linkage between the values, process, and leadership themes that emerged in the current study require a leader to ask questions so that the various understandings can be clarified. Again, the conceptual framework used for the current study assisted reaching this understanding. The leader's task is to assist people to understand and make meaning of their situations by posing questions--not by providing answers.

The three leadership themes that emerged were vision, communication, and teaching, and an implication from the study is that organizational effectiveness will be enhanced if all group members are able to contribute to these aspects of leadership. The implication for administrators--including those in traditionally bureaucratic organizations-- is that if members of an organization are provided the opportunity to contribute to the definition of the values, processes, and direction-setting for their organization a positive, creative, and proactive organizational climate can be the result.

The sharing of leadership requires the separation of leadership and position in the minds of the group members, particularly those on higher levels of any organizational hierarchy that exists. The preparedness of administrators to involve group members in such activities requires the taking of a philosophical position that all group members are stake holders and not only do they have the right to demand control of their organizational lives they have the potential to contribute to the improvement of the organizational lives of all. In this manner, in the words of Lao-Tsu, the members of the group will be able to say, "We did it ourselves."

Implications for Further Research

A major limitation of the current study was that it was the study of an inter-agency group when a new organization was being planned and the politics of the situation demanded that no hierarchy exist or be implied to exist with regard to the participants in the study. Thus, although the participants brought understandings of their own organizations with them to the study these assumptions could only be applied to their new organization because there was no existing organizational history around which a culture had had the opportunity to grow.

As health administrators the participants brought to the group similar values but they exhibited a variety of assumptions about the organizations in which they were involved. This variety of assumptions did present difficulties in the creation of the new organization but there was a sufficient degree of commonality in them for the differences to be overcome, at least in the planning stage for the organization that comprised the subject of the study.

With the exception of those from Timberwell Hospital, the participants did not carry with them assumptions about the same organization, so there were no long-held assumptions that comprise the deepest level of organizational culture that, as described by Schein (1985), required unfreezing. Further research that investigates how a problematic situation in a single organization is addressed could well assist in further increasing the understanding of leadership and how leadership is manifested as a shared phenomenon.

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Appendix I: Health Care Program

GOAL:

To provide an effective continuum of health care to individuals in the appropriate setting at the appropriate time.

PROGRAM COMPONENTS AND SERVICES:

Home Care

Services provided:

monitoring, counselling, direct nursing care in the home, palliative care, referral to acute and LTC.

Providers:

Timberwell Health Unit

Institutional Care

Services provided:

primary, secondary, auxiliary and long term levels of care; referrals to tertiary-level care; emergency/out-patient services; palliative care.

Providers:

Timberwell Nursing Home, Eaton Hospital, Timberwell Hospital.

Fee-For-Service Providers

Services provided:

primary-level care; referrals to acute/long-term care; physiotherapy; diagnostics.

Providers:

Medical Clinics, Physiotherapists, etc.

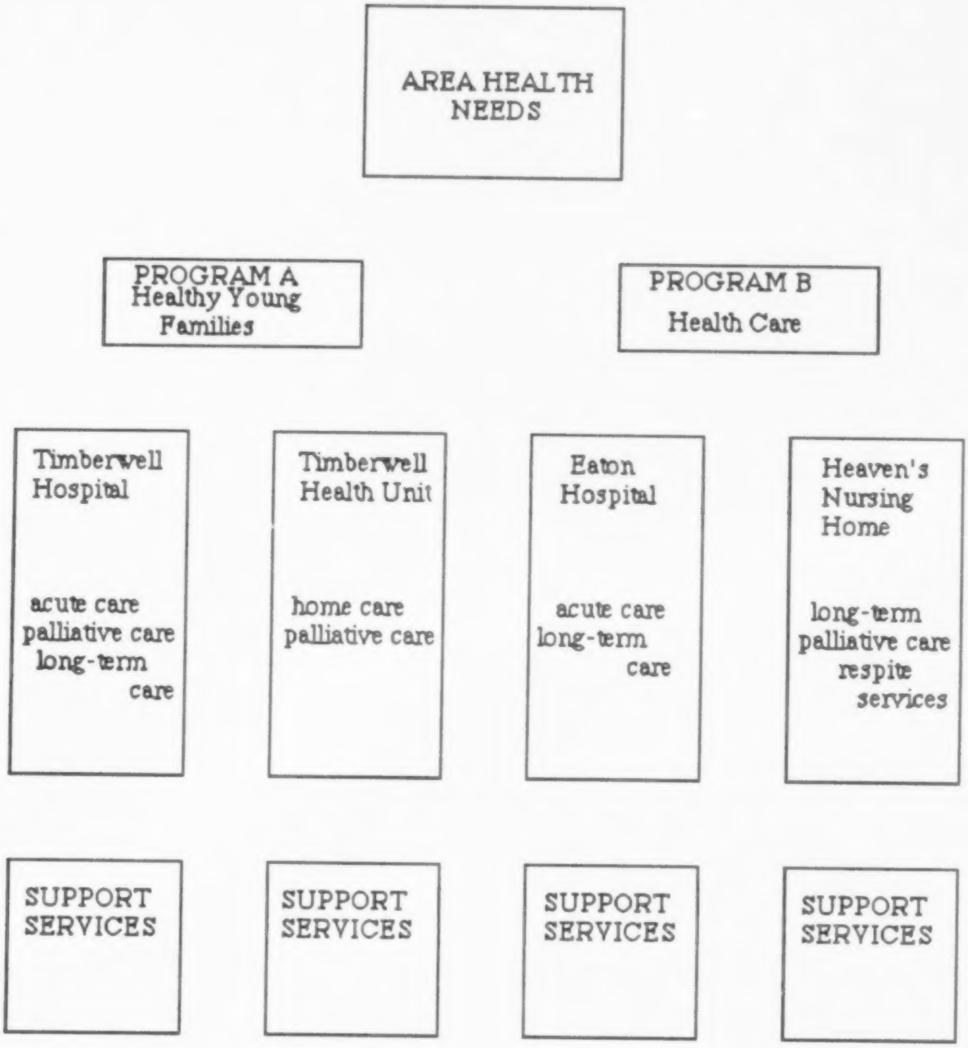
Other Non-Governmental Organizations

Services provided:

counselling, monitoring, referrals to other levels of care.

Providers:

Societies, Support Groups.


AREA HEALTH NEEDS
PROGRAM A Healthy Young Families
PROGRAM B Health Care
Timberwell Hospital
acute care
palliative care
long-term care
Timberwell Health Unit
home care
palliative care
Eaton Hospital
acute care
long-term care
Heaven's Nursing Home
long-term
palliative care
respite services
SUPPORT SERVICES
SUPPORT SERVICES
SUPPORT SERVICES
SUPPORT SERVICES

Appendix 2: Extracts From *Community Health Campus: Draft.*

A proposal which is linked to changing modes of health care deliver for the Timberwell Hospital District.

Where health delivery is concerned, it appears that outdated forms and frameworks far outlive needs they were intended to meet. These measures also serve to constrain and handicap efforts which might enable our hospital district to adapt to new needs. This is nowhere more vividly apparent in the design of our present facility.

Delivery of health care is being reshaped, not only by rapid advances in our understanding of disease process, but by new diagnostic and therapeutic technologies which sharply lower morbidity caused by treatment . . .

As the centre of gravity in healthcare shifts into the ambulatory and sub-acute arena, contemporary healthcare facility design seems to remain a prisoner of an outdated model of interaction between physicians, patients and their families. This model assumes that the exigencies of disease require that health care professionals take custody of patients for extended periods of time, removing them from their families, their communities, and their culture until their illness has been defeated and they are restored to their vitality. . . .

Out of our undifferentiated Canadian market for acute care emerging two distinct markets: critical care or community based ambulatory and chronic care. . . . Critical care is organized around concept of team-based care to desperately ill patients by highly specialized physicians and other care givers. It is for this reason that the functional departments of the traditional hospital (nursing, social work, dietary, etc.) become far less relevant to the organization of critical care than the critical condition itself. A good example would be today's trauma patient may transit multiple departments (such as emergency, radiology, surgery, post-surgical recovery) and to be handed from group to group within the hospital before stabilization, or as is most often the case in Timberwell, transfer.

Emerging technologies will eliminate the need for much of the above patient movement especially elevator rides and passed (sometimes dropped) batons. In fact, today acute intervention rooms where the patient with a myocardial infarct receives thrombolytic therapy, is stabilized and is put into critical care stabilization unit, does exist. This process enables the same clinical team who save that person's life to also monitor the patient's recovery. With the critical care market dissolving into a new market, ambulatory and chronic care services -- that is, sub-acute or short stay care for earlier stage disease. Many of the highest new technologies such MRI and cold lasers are migrating into this setting, making it possible to test very complex disease without separating patients form their families for more than one or two hours. . . .

Team Care Not "Top Gun"

The doctor side of the traditional doctor/patient relationship is changing just as rapidly as the patient side. The real doctor for a chronically ill, elderly patient today is not merely the primary care physician or specialist in the relevant chronic care physician or specialist in the relevant chronic care disease, but multi-disciplinary team on whom that physician relies for advice and management help. Diabetic care, cancer care, rehabilitation, and increasingly cardiac care is being organized along this model.

To function effectively, the work space of these professional teams must be designed to encourage easy and spontaneous interaction. Professional offices of related sub-specialists should be located together.

At the same time, the diagnostic and therapeutic workshops of professionals should be, to the maximum extent possible, co-located with their offices so that easy transit from the office to the workshop can be made. Workshops will need to accommodate not only technology, but space for informal consultation and conferencing as well as for interaction with family members before and after evaluation or treatment.

Appendix 3: Sample Field Notes.

Terry, Bobby, and Donald met in Terry's office and were discussing HPI.

T: People who are playing the system are going to get caught in the system.

D: What we lose on the in-patient side we'll make up on the out-patients.

T: Really the problem we're having is with Medical Records. The bigger hospitals are all copping it.

They began a general discussion of their financial problems.

B began to talk about the regional meeting.

B: Big Valley were saying, "I'm confused." We said, "We're not."

T: Maybe they don't want to change.

B: They're beginning to. They were asking about this [inter-agency] group.

D: It's multi-agency. The important thing is to get away from hospitals. We want to keep people out of hospital. In Michigan they do because they want to change.

T: They'll go the Canadian system.

B: But we also need alternative treatments for rural hospitals. They're looking at five different models. Some places feel threatened. It's not just a choice to survive or close -- it's about service.

D: Is someone going to the rural conference?

T: Yes, B. She'll come back with lots of info.

B: It will be interesting to see what the government does with the report.

T: This meeting shows we're not rural.

B: Mental Health got that message.

B left the room and D & T continued to talk.

D: I want to talk to the nursing management. They're confused about what they have to do [relating to the new system of scheduling].

T: Have a talk and we can discuss strategy.

D: Give me 20 grand and I'll build you a super system!

Appendix 4: Sample Interview Schedule.

1. How does the leadership work here?

2. What does leadership mean to you?

3. What leadership role does Terry play?

4. What leadership role do you play?

5. What leadership roles do others play? Who are the other leaders?

6. Does Terry do anything to involve others in the leading? If so, what does he do?

7. How do you go about working with others? Are there any guiding principles?

8. What do you see as the future for this hospital?

9. Does the hospital have a general direction that it is travelling in? If so, how did this happen?

10. If you were able to make any changes as to how the hospital runs, what would you do?

11. Do you feel that there is a unity of purpose here? If so, tell about it.

Appendix 5: Sample Interview Transcript.

Interview with Dr. Smith 20/8

What are your general impressions of how the regionalization process has been going?

Well, I'm finding it very confusing. The Department of Health has given us some expectations but very little guidelines. They're leaving it up to the local areas to try to try to figure out what to do but in my way of looking at things or the way I would have done it, I like things a little more structured so I think possibly more guidelines, a little more detail of what they're looking for. They've given us this 40,000 population and a $25 million budget as a sort of minimum but it looks like in a lot of cases that that is being viewed as a standard. We're expected to talk to other health care agencies and discuss forming networks and so on but we still don't know who to talk to because we have no idea who will be part of the network.

In addition there's still the suspicion that there's a secret map in La Fontaine that's going to be imposed upon the areas and that they've set us up for a fall. They say go out and do it but we don't know what it is that they want us to do. We go up to La Fontaine on October 6 and they you haven't done what we wanted done so they're going to impose it.

So I'm finding it very difficult. Also, the hospitals are the key players in this process and the acute-care system has always been dominant in health-care field. Public health has always been secondary, so it's the acute-care system that's running this process and all of the discussions have been based on the needs of hospitals and hospital districts and boundaries. Health unit districts and boundaries are not really even discussed at any of the meetings I've been to.

So what's happening in this area here is a group is forming at Timberwell, which I'm a part of, but there's also a group forming north of here and we don't know what the boundaries of that will be but the area I'm responsible for will be involved in at least two planning areas. That makes it very difficult for me to envision providing a public health service to two planning areas. If they decide that the boundaries between planning areas and health units must be co-terminus that means that this health unit will be cut in half. Whether they'd be two heath units or not we have no idea.

Having said that , I've concluded that here at Timberwell that no matter what the boundaries are that the Timberwell hospital and the health unit, at least the south area of the health unit here in Timberwell, will be together in no matter what configuration arises so therefore I'm proceeding to work with this group on the basis that whatever we decide here, regardless of the future, we could still carry on working together in the ways that we've agreed upon.

Why are they looking like working together regardless?

Well, there is a clear expectation from the government that health agencies have to coordinate what they do a little better and avoid duplications -- although there aren't that many duplications, I think people misunderstand what a duplication is. Also to avoid gaps and to increase efficiencies. There could be efficiencies by having shared administration and those types of things. So with ever increasing pressure on budgets it makes sense to work together with local agencies and to get together to see what we can do to get the job done with existing resources. I think we could better deploy our local resources than what we are doing currently. We could made improvements. So we think here that we could give a better service at least with no additional resources, if not actually saving money.

After a meeting last week you made the comment to me that the way that things are operating here is not the same as is operating in other places that you are aware of.

No. In some of the other areas that I am aware of and of course in my past experience, is that the health agencies are quite competitive with each other, very territorial, and very reluctant to get together and actually discuss not only sharing services but the possibility of one agency giving up some of its service provision to another, rather than have two agencies do it.

But what I've discovered here, to my delight, is that there is a past history here of the health unit and the hospital working together, even to the point where the hospital has provided some of its resources to a community program--which is actually assisting the health unit do its job. That's an unusual event in my experience when you actually give up some of your resources. That's made it quite easy for me to work with the hospital administrator because basically I trust him, that he means what he says and that he's willing to share and work together. It's not just saying it because that's what's expected.

Relating that to your idea that the key players are the hospitals, there's an implicit pecking order.

Yes, the key players have always been the acute care systems--the hospitals and their budgets. Public health, the entire public health system operates, I think they're the figures, on five percent or less of total health expenditures. To my surprize, when I came here, I found that the acute-care system, the hospitals, are expressing some fear of the health units, that somehow the health units will somehow rise up and get control of the system and take it away from the hospitals. Some of the maneuvering I've seen at other meetings--not at Timberwell--I was having difficulty understanding what was going on until in some after-meeting discussions I was having with some of the people, one of them finally came out and said to me that the reason that some of the debate went on was that the hospitals were going to make damned sure that the health units didn't get control of this process. And the hospitals are quite effective at doing that.

But that's not an issue here?

That has not been an issue with the Timberwell hospital. I think what you are observing happening here is fairly unique, although it's not necessarily not happening anywhere else, but I think it boils down to a very simple fact that neither Terry not I are trying to get control of the system. I have no desire to be a super-CEO or something or other. I personally would like to do my public health work in whatever organization that arises and I think that Terry thinks the same. He's not on a power trip to personally get control of it. I think we have a trust that we could work together without one or the other taking advantage.

I guess what's happening here is that there is some trust between the two organizations and we can get on with it and work together.

Appendix 6: Sample Theme File.

Boundaries & Territorialism

D: 7: 23: 12
BE : 8: 20: 1
PS: 8: 20: 2, 11
BO: 9: 14: 6, 9
W: 9: 15: 3, 5
T: 9: 18: 11
T: 9: 25: 2
BO: 10: 8: 8
T: 10: 14: 1
BE: 10: 18: 5
W: 19: 14: 1
BO: 10: 18: 12
V: 11: 2: 6
W: 11: 16: 5
W: 11: 16: 11

D: 7: 23: 12
Yes, but as Winifred said, we have to get above territorality and look at the good of the community. She accepted that the governance might change. That was put on the table. The organizational interests can be put aside.

BE : 8: 20: 1
I think the biggest problem right now is the turf. The turf, you know, everybody wants to keep what they have, knowing that we can't keep what we have. I think that as employers we're concerned of not only meeting what the community needs but also, for this facility, to make the right decisions for our employees so that they can keep their jobs.

PS: 8: 20: 2, 11
In some of the other areas that I am aware of and of course in my past experience, is that the health agencies are quite competitive with each other, very territorial, and very reluctant to get together and actually discuss not only sharing services but the possibility of one agency giving up some of its service provision to another, rather than have two agencies do it.

PS: 8: 20: 11
And yet the planning areas that are forming aren't based on health unit boundaries and they don't have the population sizes that we feel are necessary. So the hospitals are viewing this that the health units are somehow going to get control of this and some of the health units are looking at this as this is the end of us!

BO: 9: 14: 6
There again, what if that happened while in the other areas they're still talking about this terrible robbery that's going on. And here it doesn't seem to be an issue. Even with the boards where they're talking about getting rid of the boards and joining up. I don't know. And Rob does have a piece of that but I'm not sure he should get the credit.
I don't know whether it's best described as credit or being a catalyst.
Yes, I don't know. . . . Perhaps part of it, and yet it's come about so quietly that I'm quite surprized that there is this talking about boards at this level, and so positive.

And these other guys in the other places have got a position to defend? Exactly. They're protecting their turf and I don't think that that's happening here at the board level.

BO: 9: 14: 9
So it was positive. It was a good meeting. Again, no one was too protective of their turf, we worked together, we shared our data.

W: 9: 15: 3
I'm in the Marwell Health Unit, and those things are going to have to be negotiated, too. And already there's a lot of unrest from the different sectors saying this is my turf and no this is your boundary and all that kind of stuff -- not grasping the concept that it's not boundaries that should be talked about.

W: 9: 15: 5
The directives that are unclear. They're saying one thing and they're telling us to do one thing and there's all these unanswered questions about these relationships, the other people that they're funding, and so forth, the other sectors, like public health for instance, that are included in the funding because they have different boundaries and they want to keep their boundaries, the health units need so much, they've got to have so much population.

T: 9: 18: 11
I think that as far as the providers, we are going to have to find something that we have a mutual interest in for each of us and we can work together. That's going to add a new dimension. We have tried that and it hasn't worked in the past, I guess again because people are very territorial and want to hang onto what they have.

P: 9: 25: 2
what we're doing here is a bit different from what they're doing elsewhere. Just the concept or area-wide programs, I don't know if anybody else has used that concept to plan around. Most of the discussions I have attended have been based on boundaries or what can one hospital do for the other hospital--we'll do your laundry or we'll do your personnel . . .

BO: 10: 8: 8
I thought from the reports--Neville Baldwin had been in touch with Terry, and with Patrick, and with Warren, and seemed to make it quite clear that he just doesn't want to know. "Stay out of my territory and don't talk to me!"
Yes. You're wrecking my plans! So that is going to be a problem that will have to be handled. Interesting problem. Because this program, and teen health would be another one that really would be based through the health unit -- that would be the primary group to organize that because it's a community program. There again, there will be that concern about territories. So it'll have to be worked out.

T: 10: 14: 1
I think that people are now thinking about how they fit into the whole scheme of things and from my point of view I knew from the start that no one would want to give up territory and we would be included in that.